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MEMORANDUM

DATE: January 20, 2000

TO: Interested Parties

FROM: Peggy L. Bartels
Administrator

SUBJECT: *Wisconsin Medicaid HMO Comparison Report: 1997*

The Division of Health Care Financing (DHCF) is pleased to present the *Wisconsin Medicaid HMO Comparison Report: 1997*. This report provides information on the 1997 performance of Wisconsin Medicaid contracted health maintenance organizations (HMOs). This report is different from its predecessors in several important ways:

- No fee-for-service comparison data is included.
- The report is arranged in sections reflecting the Health Plan Employer Data and Information Set (HEDIS) reporting format for managed care organizations. HEDIS is a nationally recognized set of clinical and administrative quality indicators used by Medicare, as well as many Medicaid and private HMOs.
- HMO trends for 1996 and 1997 are presented where possible.
- The results of some Quality Improvement Initiative activities/studies are included.

Absence of fee-for-service data

This report covers the first year of statewide HMO expansion and includes data for 18 HMOs and 70 counties. Newly participating HMOs reporting on health care activity have not yet established a sufficient database for some indicators to permit meaningful inter-HMO comparisons. In those instances, this report presents data in a more aggregate form, comparing Milwaukee County HMOs to HMOs in the rest of the state. The Milwaukee County HMOs are those with a longer experience in Wisconsin Medicaid.

HEDIS reporting format for managed care organizations

This report reflects the National Committee for Quality Assurance (NCQA) reporting format, grouping the reports on the delivery of health care services to the Medicaid managed care population into the areas of:

- Access and Service
- Staying Healthy
- Getting Better
- Living with Illness

In this way, the HMO rating system that will be used by NCQA to report to consumers will be the same format used to report comparative information about HMO performance in delivery of healthcare services to the Wisconsin Medicaid managed care population. (A fifth category, Ensuring Quality Providers, is not included as a part of HMO activity in this report.)

HMO trends are presented

This edition of the annual HMO Comparison Report includes data which compares HMO activity for the years 1996 and 1997, where appropriate. Since many of the HMOs began serving the Medicaid population in 1997, this report only presents comparative data for 1996 and 1997 for HMOs in Milwaukee County. In an effort to provide meaningful trend data, the DHCF has made every effort to use the same indicators and reporting requirements in each reporting year. As reporting mandates change it will be necessary to add indicators, but every effort will be made by the DHCF, working with HMO information personnel, to maintain reporting standards and requirements.

Quality Improvement Initiative activities/studies

The DHCF has developed multiple Quality Improvement (QI) strategies for reporting on the quality of care delivered to the Medicaid population by managed care organizations. In developing these strategies, the DHCF has consulted with the managed care organizations, review agencies, and other state agency personnel. These QI strategies, which are described in greater detail in the report, include ongoing activities of the HMO technical workgroup, data validity audits, and focus studies. The goal has been to establish a method for reporting on managed care activity that accurately and reliably reflects and improves the quality of healthcare services provided to Medicaid enrollees.

The *Wisconsin Medicaid HMO Comparison Report: 1997*, includes an Executive Summary which highlights the clinical findings from the date reported by the HMOs. Please refer to this summary and the accompanying report for details on these findings.

Questions concerning this report should be directed to Angela Dombrowicki at (608) 266-1935.

PLB:mhy
MA12013.RC

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Wisconsin Medicaid
HMO Comparison Report: 1997

Wisconsin Department of Health and Family Services

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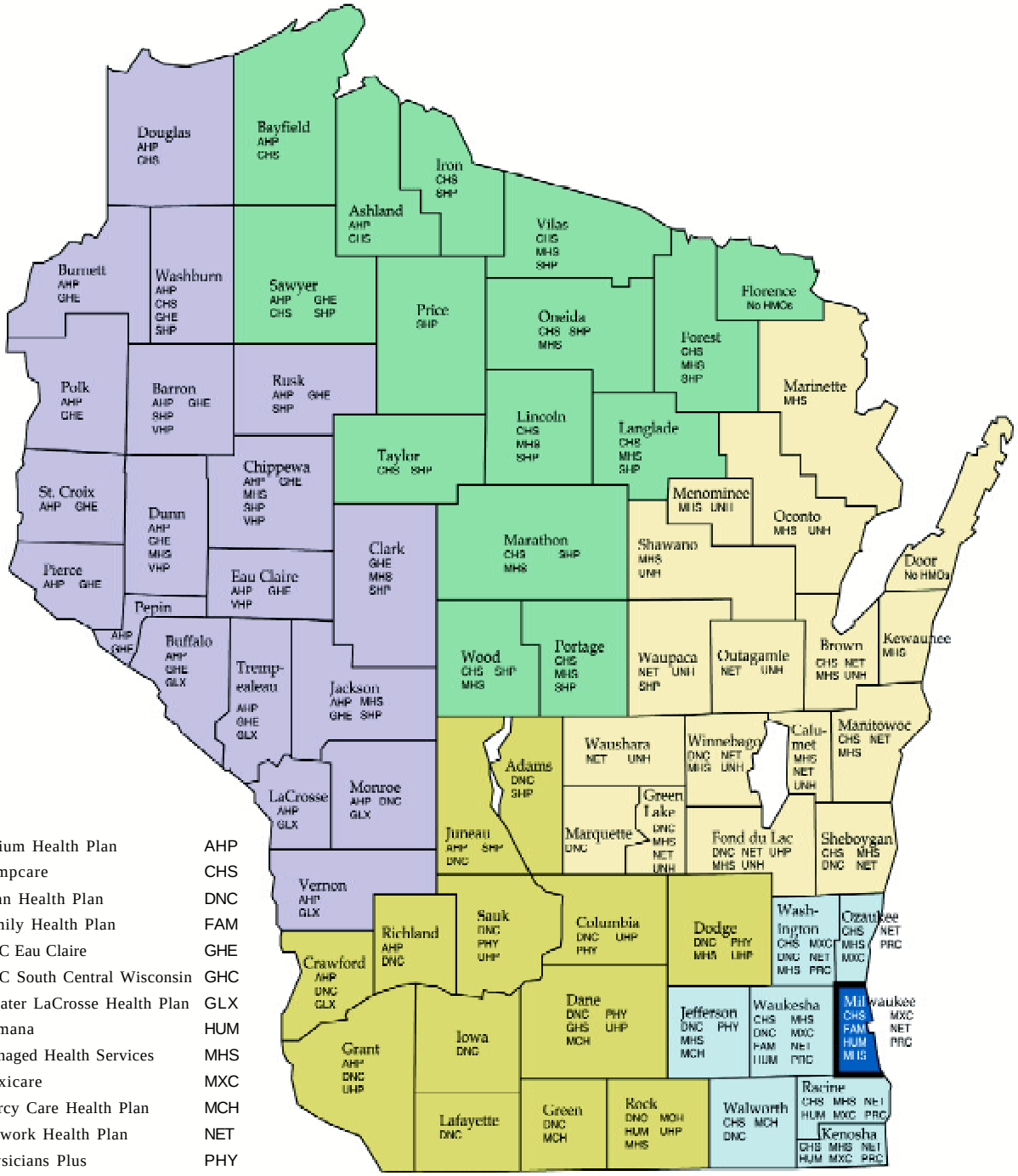
Map 1

HMO participation in Wisconsin Medicaid, by county, 1997



Atrium Health Plan	AHP
Compcare	CHS
Dean Health Plan	DNC
Family Health Plan	FAM
GHC Eau Claire	GHE
GHC South Central Wisconsin	GHC
Greater LaCrosse Health Plan	GLX
Humana	HUM
Managed Health Services	MHS
Maxicare	MXC
Mercy Care Health Plan	MCH
Network Health Plan	NET
Physicians Plus	PHY
PrimeCare	PRC
Security Health Plan	SHP
United Health of Wisconsin	UNH
Unity Health Plans	UHP
Valley Health Plan	VHP

Note: These abbreviations appear on various tables throughout this report.

Interpretation of Data

Comparative Data

Comparative data are reported for HMOs in Milwaukee County that participated in the Medicaid program during 1996 and 1997. One HMO (Network Health Plan) began participating in the Medicaid program in 1997; therefore, data are reported only for that year.

Aggregated data for counties in the rest of the state (i.e., non-Milwaukee counties) are reported for only 1997 because there are limited data available for 1996. This aggregation of data for the rest of the state was a result of enrollee distribution and HMO participation during the reporting year.

The terms "non-Milwaukee counties," "other counties," and "rest of state" are used interchangeably in this report. The term "statewide" was not used in order to avoid misinterpreting the data as including fee-for-service data or as representing all counties. This is strictly a report on managed care data provided to the Department of Health and Family Services by Medicaid HMOs for those counties with HMO participation during the reporting year.

Data Definitions

The number of months that individuals are eligible for Medicaid benefits varies by HMO and area of the state. In order to compare data from different HMOs or areas of the state, most data in this report (e.g., number of services, number of visits) are adjusted for the average years of eligibility. This number is calculated by dividing the number of visits made by, or services provided to, recipients by the number of eligible-years for the eligibles receiving the particular service. Refer to the *Wisconsin Medicaid HMO Comparison Report: 1997 Data Tables* for definitions of all data terminology used in this report.

Section 1
Overview

What's New in This Year's Report

Data in the *Wisconsin Medicaid HMO Report: 1997* are reported in a manner that reflects the statewide expansion of managed care for the Aid to Families with Dependent Children (AFDC)-related and Healthy Start population in late 1996 and 1997. In 1997, forty-six percent of Medicaid HMO enrollees resided in Milwaukee County. The remaining fifty-four percent of Medicaid HMO enrollees were distributed in the remaining 69 counties with HMO participation in 1997. Participation in these remaining counties varied by HMO, with some counties having a very small number of enrollees for any given HMO. This makes it difficult to consistently report statistically valid numbers if the utilization data are not aggregated for the rest of the state.

Map 1 shows HMO participation by county. This map also depicts regions of the state used for aggregate regional reporting in the supplementary report, *Wisconsin Medicaid HMO Comparison Report: 1997 Data Tables*. This report provides data aggregated by region of the state and is available upon request.

Fee-for-service data are not included as a comparison to HMO data, since HMOs provided services to Medicaid recipients in 70 out of 72 counties in Wisconsin in 1997. The fee-for-service data for the AFDC/Healthy Start Medicaid population in 1997 were minimal and not a valid comparison to HMO data.

Data are organized into four broad categories used as part of the National Committee on Quality Assurance (NCQA) accreditation of health plans (i.e., Access and Service, Staying Healthy, Getting Better, Living with Illness). The data within each category are organized by indicator, such as "HealthCheck Screens." Some of these indicators are based on Health Plan Employer Data and Information Set (HEDIS®) measures used to report health plan performance for commercial, Medicaid, and Medicare plan members. Other measures reflect the characteristics of a population which is predominantly women and children (i.e., individuals who are Medicaid-eligible under the Healthy Start and former AFDC programs).

This year's report includes expanded reporting of Division of Health Care Financing quality oversight activities such as data validity audits, Quality Improvement (QI) studies, and a recipient satisfaction survey.

Introduction

The Wisconsin Medicaid HMO Comparison Report is an annual report published by Wisconsin Medicaid. This report is one of several ways Wisconsin Medicaid monitors and reports on care provided to Medicaid recipients enrolled in HMOs: individuals who are Medicaid-eligible under the Healthy Start and former Aid to Families with Dependent Children (AFDC) programs.

In keeping with the 1996 report, this report of health care delivered in 1997 includes only those utilization indicators previously used that relate to quality of care. Every attempt has been made to use the same reporting format so that HMOs will be able to identify a trend in their activities reported to the Division of Health Care Financing. Data from all eighteen Wisconsin Medicaid managed care organizations are included.

Wisconsin Medicaid AFDC/Healthy Start-specific data utilized in findings, graphs, and tables are from multiple sources. HMO utilization data are generated and reported by individual Wisconsin Medicaid HMOs. Eligibility data for recipients enrolled in HMOs are extracted from the Wisconsin Medicaid fiscal agent's eligibility files.

The data in the *Wisconsin Medicaid HMO Comparison Report: 1997*, like most health care statistical reporting, must be interpreted with recognition of variables that may influence the data. For example, differences between individual Medicaid HMOs may represent different levels of HMO performance or they may represent demographic and other differences among the enrollees served by the HMOs. Comments regarding those variables and their importance are noted in the report as appropriate.

Executive Summary

The *Wisconsin Medicaid HMO Comparison Report: 1997* presents data on health care delivered by HMOs during a year of statewide HMO expansion for Wisconsin Medicaid. With the expansion of managed care, the Division of Health Care Financing expanded its quality review oversight activities. These activities included conducting a data validity audit for all HMOs, a member satisfaction survey for Milwaukee County enrollees, an increasing number of chart audits for enrollees in HMOs, an analysis of HMO-conducted quality improvement studies, and two projects focusing on behavioral health services.

Data analysis reveals that:

√ For most health care areas measured, health service utilization has been quite stable relative to 1996. This suggests that the HMO expansion, while massive in scope, has not resulted in decreased service availability for enrollees.

√ HMO enrollees in Milwaukee County are largely satisfied with their care.

√ Relative to 1996, there were slight to moderate improvements in the utilization rates of:

- HealthCheck screens.
- Non-HealthCheck visits.
- Cesarean sections.
- Pap testing.
- Mumps, measles, and rubella (MMR) immunization.
- Hospitalization for asthma.

√ Improvements probably reflect both improved data reporting by the HMOs and increased provision of services.

√ Improvements are still necessary in most areas of health care, but particularly in dental services and behavioral health care.

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Section 2

Wisconsin Medicaid

What is Medicaid?

Medicaid is a joint federal/state program established in 1965 under Title XIX of the Social Security Act to pay for medical services for the poor and disabled. In Wisconsin, Medicaid is administered by the Division of Health Care Financing in the Department of Health and Family Services.

Who Pays for Medicaid?

Both federal and state tax dollars support Medicaid. For state fiscal year 1997 (1996-1997), Medicaid expenditures were $2.45 billion. Of that amount, $865 million was contributed by the state and nearly $1.59 billion by the federal government. For state fiscal year 1998 (1997-1998), Medicaid expenditures were $2.52 billion. Of that amount, $905 million was contributed by the state and $1.61 billion by the federal government.

Medicaid is the second largest program in the state's budget, representing 9.3% of total state-funded expenditures. Increased costs are primarily attributable to expanded eligibility and rising health care costs.

Who is Eligible for Medicaid?

In calendar year 1998, approximately 557,000 Wisconsin residents were eligible for Medicaid for at least some time during the year. The average monthly caseload was 426,720.

Four major groups received medical services through Wisconsin Medicaid in 1997: the aged, the blind/disabled, the Healthy Start population, and recipients who qualified under the former Aid to Families with Dependent Children (AFDC) standards. Of the total Medicaid-eligible recipients, well over half were eligible through AFDC or Healthy Start, and this population accounted for 19% of Medicaid expenditures. The aged/blind/disabled made up approximately 35% of the population and accounted for approximately 81% of the program expenditures.

The AFDC/Healthy Start recipient group, which is the subject of this report, is comprised of pregnant women, children, and families with children who meet various low-income criteria.

Medicaid Managed Care

Wisconsin was one of the first states to initiate managed care for the AFDC/Healthy Start Medicaid population by receiving a federal waiver to pursue the managed care alternative in the early 1980s. Since that time, many states have adopted managed care as a model of service delivery.

The Wisconsin Medicaid HMO program expanded statewide in 1996 and 1997 beyond the original five counties included in the 1996 report. Expansion for the AFDC/Healthy Start population into additional counties occurred systematically in three phases starting in the eastern Wisconsin counties. By the end of 1997, over 290,000 Medicaid recipients had been enrolled in 18 HMOs in 70 counties for at least a part of that year.

Table 2.1 lists the HMOs included in this report, and the average number of months recipients were enrolled in the respective HMOs in 1997. This average is important because it affects an HMO's ability to influence an enrollee's health outcome. In general, Medicaid recipients are enrolled in HMOs for shorter periods of time than are commercial subscribers, partly because enrollment is dependent on individuals meeting financial eligibility requirements for the Medicaid program.

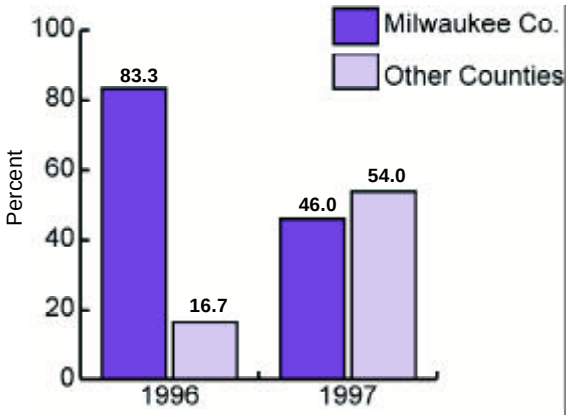
Table 2.1

Number of recipients enrolled in participating Medicaid HMOs and duration of enrollment: January 1 – December 31, 1997

Managed Care Organization	Milwaukee County		Rest of State		Statewide	
	Number of Enrollees	Average Enrollee Months per Recipient	Number of Enrollees	Average Enrollee Months per Recipient	Number of Enrollees	Average Enrollee Months per Recipient
Atrium Health Plan	N/A	N/A	13,541	5.90	13,536	5.90
Compcare	26,561	8.44	23,197	6.51	49,587	7.58
Dean Health Plan	N/A	N/A	13,575	6.19	13,620	6.19
Family Health Plan	2,702	6.85	290	6.60	2,994	6.84
GHC - Eau Claire	N/A	N/A	6,964	6.66	6,985	6.66
GHC - South Central WI	N/A	N/A	3,547	7.37	3,542	7.37
Greater La Crosse Health Plan	N/A	N/A	5,227	6.56	5,235	6.56
Humana	28,215	8.50	4,492	6.14	32,676	8.20
Managed Health Services	18,615	8.29	17,671	5.90	34,906	7.16
Maxicare	12,763	8.92	2,601	7.04	15,342	8.62
Mercy Care	N/A	N/A	4,232	6.42	4,237	6.42
Network Health Plan	747	4.82	15,351	6.29	16,122	6.23
Physicians Plus	N/A	N/A	5,075	5.94	5,098	5.94
PrimeCare	49,296	8.57	5,376	6.38	54,597	8.39
Security Health Plan	N/A	N/A	18,208	6.25	18,246	6.25
United Health of WI	4	1.25	13,921	6.45	13,959	6.45
Unity Health Plans	N/A	N/A	10,864	6.93	10,885	6.93
Valley Health Plan	N/A	N/A	5,935	6.38	5,944	6.38
Total	133,149	8.83	158,432	6.81	290,193	7.77

Graph 2.1

Distribution of Wisconsin Medicaid recipients in 1997: Milwaukee County and other counties



Graph 2.1 shows the distribution of the Wisconsin Medicaid population following expansion of HMO enrollment for 1996 and 1997. In 1997, 46% of the Wisconsin Medicaid HMO enrollees were in Milwaukee County. In 1996, prior to expansion of HMO enrollment, 83.3% of all Medicaid HMO enrollees were in Milwaukee County. Further, average enrollment was longer in Milwaukee County HMOs than in the rest of the state. This may reflect the fact that statewide expansion did not occur until 1997.

Demographics of the Population

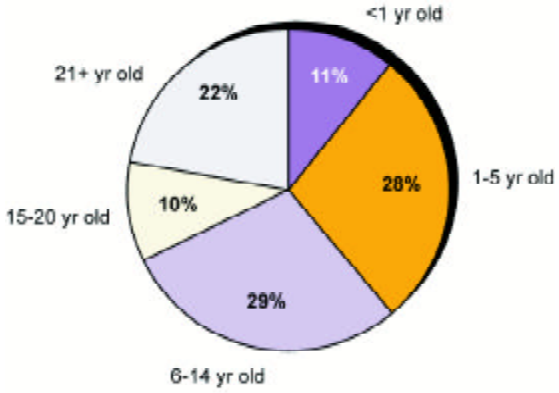
When interpreting the data presented in this report, it is important to keep in mind the composition of the Medicaid AFDC/Healthy Start population in 1997.

- Over 60% of HMO enrollees were female.
- Over 75% of male HMO enrollees were under the age of 15.
- Only 32% of female enrollees were 21 years of age or older.
- Seventy-eight percent of all HMO enrollees (i.e., male and female) were under the age of 21.

Graphs 2.2 through 2.4 present the distribution of Medicaid HMO enrollees by age and sex in 1997.

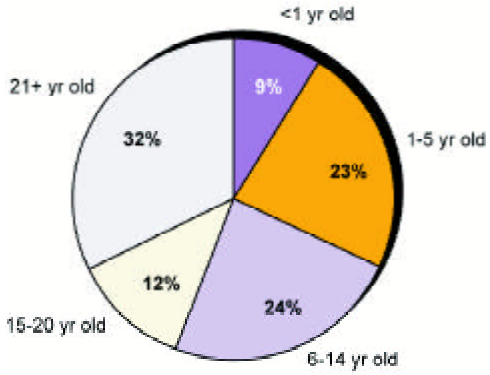
Graph 2.2

Distribution of Wisconsin Medicaid recipients in 1997: by age



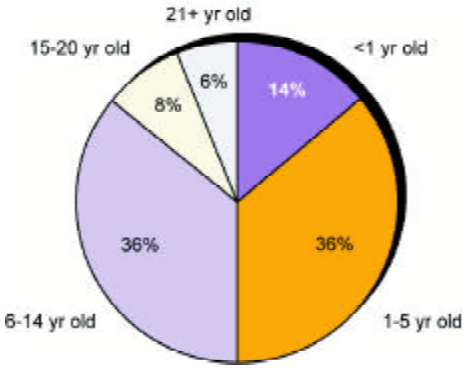
Graph 2.3

Distribution of female Wisconsin Medicaid recipients in 1997: by age



Graph 2.4

Distribution of male Wisconsin Medicaid recipients in 1997: by age



Section 3

Quality Improvement

Wisconsin Medicaid is committed to assuring quality, access, and choice to its Medicaid population, and to being a proactive partner with the private sector in achieving the highest possible health outcomes for recipients. This is accomplished through Wisconsin Medicaid Quality Improvement (QI) activities, which include many monitoring and oversight activities and public forums.

HMO Program Quality Improvement Activities

Quality Improvement activities that relate to the Aid to Families with Dependent Children (AFDC)/Healthy Start HMO program include:

- Assuring contractual safeguards, such as the requirement that certified HMOs:

  Meet licensure standards of the Wisconsin Office of the Commissioner of Insurance.

  Ensure that enrollees have timely access to primary and specialty care providers.

  Cover all mandated services, whether through internal staff or by contracted arrangements.

  Provide emergency health care services 24 hours a day, seven days a week, and provide a single telephone number through which enrollees are able to access all services.

  Provide an HMO advocate to assist recipients with using managed care effectively.

  Have an established and available grievance procedure.

  Provide specific preventive health care services.

  Establish a working arrangement with community agencies to facilitate prenatal care coordination, with a goal of decreasing adverse outcomes of pregnancy.

  Address the health care needs of the Medicaid population in a culturally sensitive fashion.

- The use of an independent enrollment counselor to ensure that Medicaid recipients enrolling in HMOs make a fully informed choice when choosing a provider.

- Establishing and maintaining ongoing methods for public, recipient, and provider input. Examples of this activity include the Statewide Advisory Group (SWAG), quarterly meetings with HMO technical staff, quarterly regional forums, and work groups established to address specific areas of concern.

- Utilizing a Medicaid ombudsman external to the HMOs.

- Measuring recipient satisfaction.

- Producing this annual report on HMO-delivered care.

- Monitoring HMO disenrollment and grievance procedures.

- Participating in data management and reporting activities, including the Encounter Data Workgroup, Data Validity Audits, and Focus Study reporting.

Fee-for-Service Quality Improvement Activities

The Division of Health Care Financing (DHCF) is responsible for monitoring quality of care in the fee-for-service area as well as in managed care. Though fee-for-service data is no longer used for comparison purposes, the quality improvement activities in fee-for-service are noted here:

- Reviews and audits of health care services delivered to Medicaid recipients in the outpatient and inpatient setting for appropriateness, medical necessity, and quality of care.

- Prospective review of selected services through prior authorization to assure recipients receive medically necessary and cost-effective services.

- Ongoing review of the utilization of drugs in outpatient and nursing home settings to assure that prescribed drugs are appropriate, medially necessary, and not likely to result in adverse medical outcomes.

Medical Chart Audit Review Activities

On an ongoing basis, the DHCF engages in a variety of audits and medical chart reviews to assess the quality of care provided to Wisconsin Medicaid recipients. Some of these audits/chart reviews are on a case-specific or limited basis, while others encompass a broad spectrum of care. The former usually represents a response to a specific complaint or grievance, while the latter generally reflects pre-planned assessments of areas of interest or concern to the Department of Health and Family Services. Because the Medicaid population consists primarily of mothers and children, audits and chart reviews are principally designed to monitor the care of that population. (Issues important to Medicaid mothers and children center around prenatal care, women's health, child health and preventive care, dental, and mental health/substance abuse [alcohol and other drug abuse] care.)

The majority of medical audit/chart reviews, from a volume standpoint, is performed by an External Quality Review Organization (EQRO) under contract with the DHCF. The questionable quality of care cases identified in managed care delivery by the contractor's physician advisers are referred to the DHCF physician staff for further review. Chart reviews and audits are focused on specific areas of concern to the DHCF. In the past, only an extremely small number of cases reviewed by the EQRO have been found to represent "medical mismanagement with potential for significant adverse effects on the patient." This is a direct result of the identification of error-prone providers in previous reviews, and effective HMO-focused corrective action plans associated with provider education.

Quality Improvement
Data Management and Reporting

The need for accurate, reliable, timely data is increasingly important for all participants in the delivery of health care. Recipients need information to make informed choices about providers and services. Providers need information to make recommendations and decisions about service delivery and resource requirements. Payer sources need information to direct inquiries about payment and contract compliance.

To meet the data needs of multiple users, the DHCF has progressively implemented quality improvement initiatives in data management to assure that the data meet user requirements. These include the HMO Technical Workgroup, Data Validity Audits, and Focus Study Reports, which are discussed below.

HMO Technical Workgroup

Over the years, increased scrutiny through enhanced editing and additional analyses of the data revealed limitations in the existing data collection methodology and the data obtained through that methodology. To address these limitations, in 1996 the DHCF decided to move toward more accurate and complete reporting of data, enlisting the help of the HMOs. As a result, the HMO Technical Workgroup was established.

The HMO Technical Workgroup brings together the information systems and other personnel from the HMOs and the DHCF. The workgroup evaluates the appropriateness and necessity of contract-requested data elements for the measurement of specific health care processes or outcomes. The workgroup gives the HMOs an opportunity to request changes in data reporting so that their respective information systems have minimal duplication of data reporting, and reporting deadlines are compatible with their respective capabilities and other non-Medicaid reporting requirements. The DHCF is afforded the opportunity to explain the data requests, and work with HMOs in achieving efficient reporting of accurate and complete data.

Currently, the HMO Technical Workgroup meets on a bimonthly basis. All HMOs are expected to have representatives of their information systems staff, as well as their quality improvement and claims processing staff in attendance as topics warrant. The DHCF is represented by staff from operations and managed care. The HMO Technical Workgroup addresses both the current data collection issues and future data collection strategies such as the proposed full encounter data set.

The current data collection methodology is to collect summary data from each HMO with a series of utilization and quality indicators, supported by a limited encounter (history) data set. The data collection methodology is structured to meet the needs of reporting required by the Balanced Budget Act of 1997, the National Committee on Quality Assurance (NCQA), the Health Plan Employer Data and Information Set (HEDIS®), and Wisconsin Medicaid.

In a move away from the collection of summarized data from the HMOs, the DHCF will require an expanded and complete encounter data set from all HMOs beginning in the year 2000. This expanded and complete encounter data set is also mandated as part of the federally required Medicaid Statistical Information System (MSIS) reporting from all state Medicaid programs.

Data Validity Audits

The DHCF conducts audits to verify the accuracy of HMO-submitted data, since health care data is key to its oversight activities. The current DHCF HMO data validity audit consists of two parts. Part One evaluates the structure and technical function of the information systems of participating HMOs. It includes the following thirteen topics of evaluation:

1. Methods used by the HMO to obtain data for HMO utilization reporting.
2. Description of administrative data system.
3. Quality control of HMO information systems.
4. Transaction forms.
5. Health services data.
6. In-house transaction processing.
7. Third party transaction processing.
8. Enrollment information system.
9. Provider information system.
10. Other system issues.
11. Calculation of performance measures:
    - Pap test.
    - HealthCheck.
    - Primary diagnosis of asthma.
    - Hospitalization for asthma.
    - Mental health and/or substance abuse evaluations.
    - Dental services.
12. Instruction, training, and feedback.
13. General difficulties.

The results of the first data validity audit, Part One, completed in 1997, demonstrated that HMOs participating in Wisconsin Medicaid managed care generally have adequate systems capability. Since Part One of the data validity audit was conducted at the HMO site, it was also a means to provide technical assistance to the HMOs, especially with respect to the last three audit topics noted above.

Part Two of the data validity audit measures the completeness and accuracy of the data that are obtained from the HMOs' providers. Part Two accomplished this by measuring the rates of agreement and error between the medical record and the HMOs' automated systems for two of the performance measures audited. The results were then analyzed to identify patterns of disagreement between medical record and administrative data.

Of the six performance measures evaluated in Part One of the data validity audits, Pap tests and HealthChecks (i.e., well-child assessments) were selected because of the prevalence of reported services and variability in reported rates between HMOs. The DHCF verified HMO-reported data through chart audits.

All Medicaid HMOs completed Part Two of the data validity audit in 1997. Scores for accuracy in reporting Pap testing ranged from 62.2% to 100%, and for completeness 68.4% to 100%. HealthCheck accuracy of reporting ranged from 40.5% to 100%; completeness ranged from 65.8% to 100%.

Pap testing reporting scores are slightly higher than HealthCheck reporting scores because verification of Pap testing can come from two sources, the performing provider and the laboratory that provides the interpretation. The lower scores in reporting HealthCheck is a reflection of difficulty in using the appropriate coding of visits to reflect the fact that they are HealthCheck encounters rather than routine or acute care visits.

Part Two of the data validity audit will be carried out for each HMO on a biennial basis. In the first repeat cycle the Pap tests and HealthCheck performance indicators will be retained. This will permit the HMOs to demonstrate improvement in data management, using the same measurement parameters of the previous data validity audit.

Focus Studies

Focus studies provide the HMOs with a unique opportunity to analyze their health care services data and define areas of concern which are amenable to study and corrective action. The HMOs are asked to identify an area that is of significance to their Medicaid population, that has measurable outcome(s) or process(es), and for which there is a possible corrective action. The HMOs are asked to select two such topics annually and to construct a focus study for each.

MetaStar, the EQRO, has developed an instrument for evaluating focus studies. The EQRO evaluates the focus studies in order to validate the study design and its conclusion(s) to assure that the corrective action plan is appropriate and will result in quality improvement of the care provided by HMOs.

In 1997, 18 HMOs participating in Wisconsin Medicaid submitted two focus studies each as required by the contract. The topics chosen included:

- Immunization was the topic of eight focus studies.
- HealthCheck was the topic of three focus studies.
- Prenatal care was selected as a topic for six focus studies.
- Lead screening was the topic of five focus studies.
- Asthma was chosen for a focus study topic in eight instances.
- Diabetes was the subject of four focus studies.
- Chlamydia screening and emergency room utilization were each selected for a single focus study.

Most of the HMOs' focus studies measured current performance against well-accepted standards which will form a strong basis for future studies designed to improve performance. The focus studies were reviewed with each HMO at on-site visits, and will be the subject of a one-day workshop sponsored by the DHCF in the spring of 1999.

The federal Health Care Financing Administration (HCFA) has developed a system for assuring quality improvement for all managed care programs participating in Medicaid and Medicare called the Quality Improvement System for Managed Care (QISMC). The central focus of QISMC is completion of focus studies in clinical and non-clinical areas of managed care activity. Though the recommendations in QISMC are not yet finalized, it is certain that focus studies will be required of all managed care organizations. The content and format of the focus studies should be applicable to both QISMC standards and NCQA accreditation standards, thus permitting HMOs to meet more than a single goal in completing a focus study.

By completing the focus study activity requested by the DHCF, the Wisconsin Medicaid HMOs will be well-positioned to provide the studies requested by accreditation agencies.

Quality Improvement
Recipient Satisfaction Survey

The DHCF contracted with the Wisconsin Survey Research Laboratory to examine the experiences of Medicaid enrollees in Milwaukee County with their HMOs. From a randomly selected survey, telephone interviews were completed for 465 Medicaid recipients in Milwaukee County in 1997.

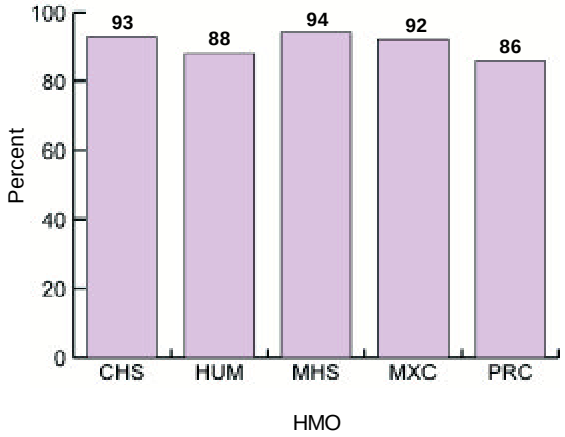
Overall, Medicaid enrollees surveyed reported favorable experiences and satisfaction with the quality of medical care provided by their HMOs.

The major findings were:

- Ninety percent of respondents believed that it was easy or very easy to get an appointment with their regular Medicaid HMO doctor soon after calling for an appointment. Responses ranged from 86% to 94%. See graph 3.1.
- Ninety-one percent believed that their doctors were either very good or good at listening to them.
- Eighty-two percent of respondents found obtaining information about their benefits and services from their health plan was easy or very easy. Responses ranged from 73% to 86%. See graph 3.2.
- Seventy-six percent of the respondents indicated that even if they could change their health care plan to another provider, they would stay with their current HMO, while only 21% reported that they would change their health plan.
- What respondents liked most about their HMO was the fact that medications were fully covered, and 44% said that there is nothing they did not like about their HMO.

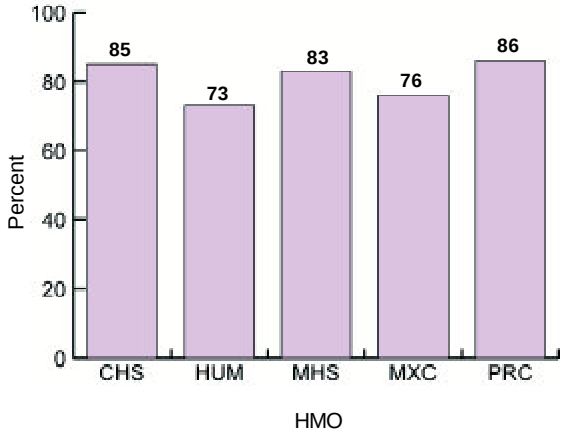
Graph 3.1

Percent of enrollees believing it was easy to obtain an appointment, by HMO



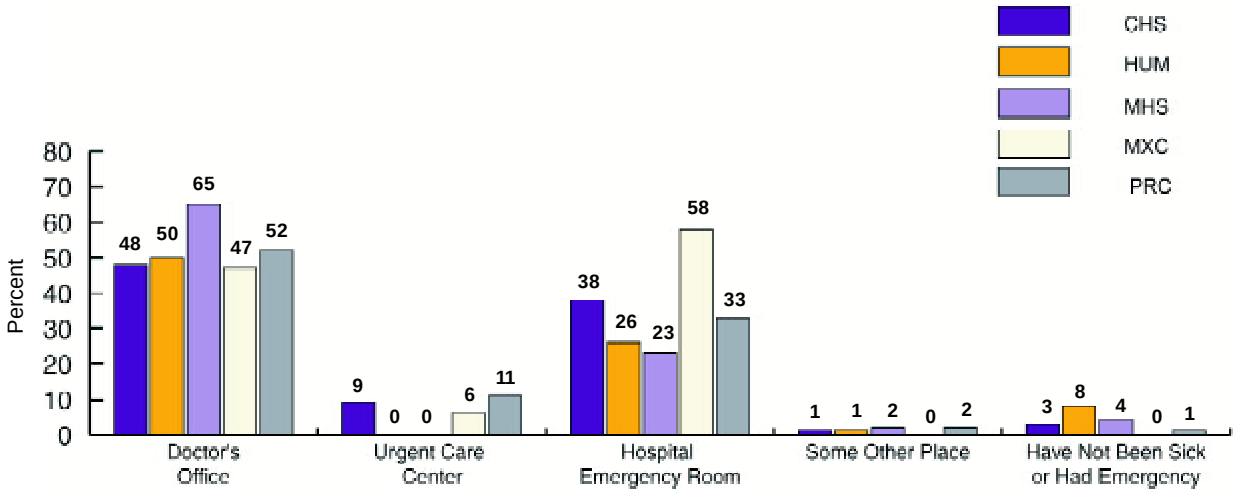
Graph 3.2

Percent of enrollees finding that obtaining information about benefits and services was easy, by HMO



Graph 3.3

Site used when sick or in an emergency, by HMO



The survey results indicate that the vast majority of surveyed Medicaid HMO enrollees are satisfied with the access and quality of care provided by their Milwaukee County HMO. One finding that will require more follow up is the site that enrollees use when sick or in an emergency. There was some variation between plans and the sites used. See graph 3.3.

Section 4

Access and Service

The Medicaid Aid to Families with Dependent Children (AFDC)/Healthy Start population represents a young, predominately female segment of the Wisconsin population. Services that are important in promoting and maintaining health for this group of Medicaid recipients include wellness checks for children, routine office care for all age groups, preventive dental care for children, Pap tests, mammography, and access to required emergency care.

HealthCheck is the service Wisconsin Medicaid provides to promote and maintain the health of children. Routine office care is measured by non-HealthCheck visits for all age groups. Routine office visits estimate the ease with which this population is able to access routine and acute care through a "medical home."

Preventive dental services for children are especially important to prevent poor dental function as the child matures. Timely, adequate preventive dental services are cost-effective in preventing significant dental malfunction, and the attendant unwanted health care issues.

Pap testing is especially important in early detection and treatment of cervical cancer. At the same time, routine examination will permit early detection of related gynecologic problems before serious, and permanent, health concerns arise. Mammography is meaningful to this population even though most Medicaid enrollees are significantly younger than the general population. The ability to detect breast lesions early increases the efficacy of treatment.

Emergency care is a vital component of services provided to any group of health care recipients. The availability and use of emergency medical care may be used to measure enrollees' ease of access to routine and acute care through their HMOs, or the establishment of a "medical home." A "medical home" should permit enrollees to use emergency care in the most cost-effective manner.

HealthCheck Visits

Components of HealthCheck Visits

Well-child assessments are an essential component in meeting preventive health care needs of children enrolled in Wisconsin Medicaid. In Wisconsin, federally prescribed well-child assessments are called HealthChecks.[1] HealthCheck permits providers to evaluate a child's physical, cognitive, social, and emotional development, identify preventable problems, screen for potential risk factors, provide appropriate immunizations and make referrals to providers and health care agencies to meet the child's health needs. Children ages 3 and older are referred for preventive and necessary dental care. HealthCheck also provides an opportunity for identifying children at risk for elevated lead blood levels, neglect, abuse, and dietary problems, as well as provide an opportunity for teaching and counseling parents.

Frequency of HealthCheck Visits

The schedule of periodic exams adopted for HealthCheck is based on recommendations by the American Academy of Pediatrics (AAP). A total of 12 HealthCheck exams are recommended to be given by the time a child reaches the age of 6. The goal of the Wisconsin Department of Health and Family Services (DHFS) for the year 2000 is "to increase to 90% the proportion of children aged birth through 5 years who receive well-child assessments through a HealthCheck exam."[2]

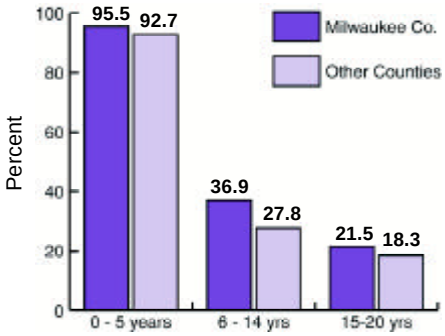
1997 HealthCheck Services

HealthCheck visits are especially important in the first years of life to ensure that children receive timely assessments to avoid medical conditions that could have long-term consequences if they do not receive early attention.

The percent of eligibles screened per eligible-year for children ages 0-5 years in 1996 was approximately 80%. The 1997 percent of eligibles screened per eligible-year, for the same age group, was approximately 94%. This probably reflects both an increase in services delivered and increased administrative efficiency in reporting.

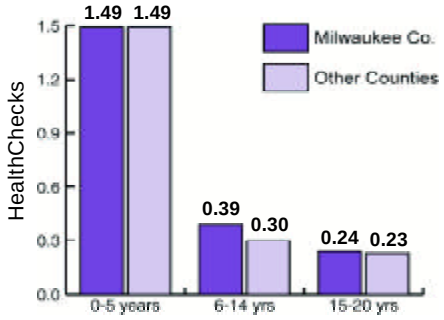
Graph 4.1

Percent of eligibles receiving a HealthCheck screen per eligible-year, by age, Milwaukee and other counties, 1997



Graph 4.2

Number of HealthCheck visits per eligible-year, by age, Milwaukee and other counties, 1997



The HMOs provide more HealthCheck services per eligible-year for preschool age children. The HealthCheck recommendations support a greater intensity of HealthCheck services within the early years of life. Graph 4.1 shows that HMOs deliver a greater intensity of HealthCheck visits per eligible recipient in the preschool years, consistent with the following federal reporting recommendations. Graph 4.2 shows a comparable number of HealthCheck visits per eligible-year for Milwaukee County and other counties.

Federal reporting recommendations include six HealthCheck visits within the first year, and 1.2 visits per year for children ages 1 to 5 years. This translates to two visits per year for children ages 0 to 5. This compares to the reported all-HMO average of 1.5 HealthCheck visits per eligible-year for the 0- to 5-year-old age group. These data do not include those HealthCheck visits obtained at public health clinics that were not billed to the member's HMO.

The 1997 average of 1.5 HealthCheck visits per eligible-year for children ages 0–5 is greater than the 1996 HMO average of 1.36 for the same age group.

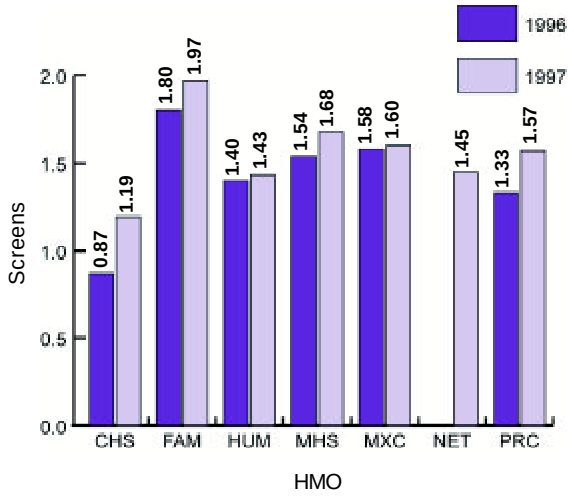
Federal reporting requirements for ages 6–14 and ages 15–20 are 0.56 visits and 0.50 visits per year, respectively. This compares to the Wisconsin Medicaid HMOs provision of 0.35 visits per eligible-year to the 6–14 year-old age group, and 0.23 visits per eligible-year to the 15–20 year-old age group. Again, this number does not include visits which may have occurred related to non-HealthCheck visits, or services provided by public agencies who do not bill the member's HMO.

Milwaukee County HMOs

The number of HealthCheck screens per eligible-year for children ages 0-5 in Milwaukee County for 1996 and 1997 is presented in Graph 4.3. All HMOs that participated in Medicaid for both years increased the number of screens per eligible-year, with the average increasing from 1.35 in 1996 to 1.49 in 1997.

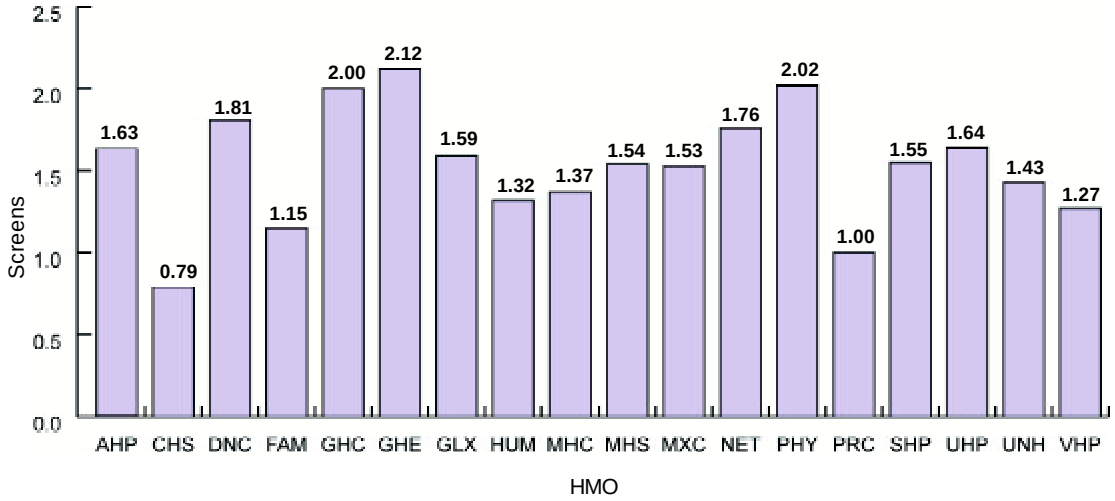
Graph 4.3

Average number of HealthCheck screens per eligible-year for Milwaukee County, ages 0-5, 1996 and 1997



Graph 4.4

Average number of HealthCheck screens per eligible-year for other counties, ages 0-5, 1997



Other County HMOs

The number of HealthCheck screens per eligible-year for children ages 0-5 in other counties is presented in Graph 4.4. The HealthCheck visits ranged from less than one visit per eligible-year to over two visits per eligible-year. For HMOs in the rest of the state, the HealthCheck services average was 1.49 visits per eligible-year, which is identical to the Milwaukee County average.

Summary

In Wisconsin Medicaid HMOs, approximately 94% of eligibles are screened per eligible-year through HealthCheck services at an early age (0–5 years). The percent of children who received a HealthCheck service and the rate of screening were higher in 1997 than 1996. The recommended frequency of HealthCheck visits per eligible-year is less as the child enters the school years and into early adulthood. The rate of HealthCheck services shown in this report follows that pattern, but may also be a reflection of services provided by the school that are not reported to the HMOs.

[1] A comprehensive HealthCheck screen includes:

- A comprehensive health and developmental history.
- A comprehensive physical exam.
- Appropriate immunizations.
- Laboratory tests (including blood lead screening and testing).
- Vision screening.
- Hearing screening.
- Oral assessment and referral to dentist at age 3.

[2] Strategic business plan: Department of Health and Family Services, 1996-2001. September, 1996.

HealthCheck and Non-HealthCheck Visits

Access to Care

Non-HealthCheck visit utilization data very likely measure non-preventive care visits received by children enrolled in AFDC/Healthy Start Medicaid. As such, these visits are an indication of the ease with which children receive routine and acute care. The availability of non-HealthCheck visits helps establish a primary care "medical home" for children enrolled in the AFDC/Healthy Start Medicaid program. The availability of primary care is essential to children's well-being. The AAP defines primary care as "accessible and affordable, first contact, continuous and comprehensive, and coordinated to meet the health needs of the individual and family being served."[1]

Non-HealthCheck Visits per Eligible-Year – Milwaukee County and Non-Milwaukee County

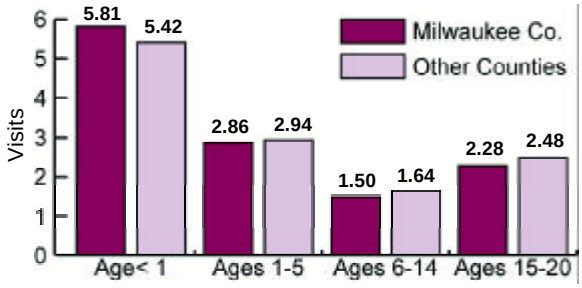
Graph 4.5 shows that the non-Milwaukee County HMOs delivered slightly more non-Health Check visits than did the Milwaukee County HMOs, with the exception of the less than one-year-old group of recipients. All the HMOs provided an average of 2.57 visits per eligible-year for ages 0-20, compared to an average of 2.4 non-HealthCheck visits per eligible-year in 1996. This increase may reflect increased provider services and administrative efficiency and data reporting stimulated by Division of Health Care Financing (DHCF) data validity audits and technical assistance.

Milwaukee County Non-HealthCheck Visits[2]

Graph 4.6 shows the average number of non-HealthCheck visits per eligible-year for Milwaukee County HMOs in 1996 and 1997. There was a slight rise in the number of non-HealthCheck visits for the entire age group 0-20 years from 1996 to 1997.

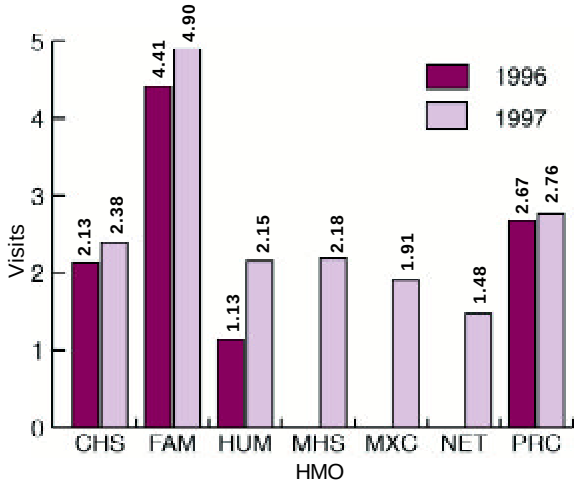
Graph 4.5

Number of non-HealthCheck visits per eligible-year by ages, Milwaukee and other counties, 1997



Graph 4.6[2]

Number of non-HealthCheck visits per eligible-year, other counties, ages 0-20, 1996 and 1997



Combined HealthCheck and Non-HealthCheck Visits – Milwaukee County and Other Counties

In 1996, the HMOs provided an average of 3.1 combined HealthCheck and non-HealthCheck visits per enrollee, per eligible-year. In 1997 the number was 3.3 visits. When all visits are combined, the Milwaukee County HMOs provided slightly fewer services per eligible-year than the other counties HMOs in the rest of the state (Graph 4.7).

The number of enrollee visits per eligible-year is an indicator of an HMO's ability to deliver primary care services to enrolled children. Taken in conjunction with the number of enrollee emergency room visits per eligible-year, this information may be useful in estimating the availability of primary care providers to see enrollees for acute problems.[3]

Milwaukee County Combined HealthCheck and Non-HealthCheck Visits

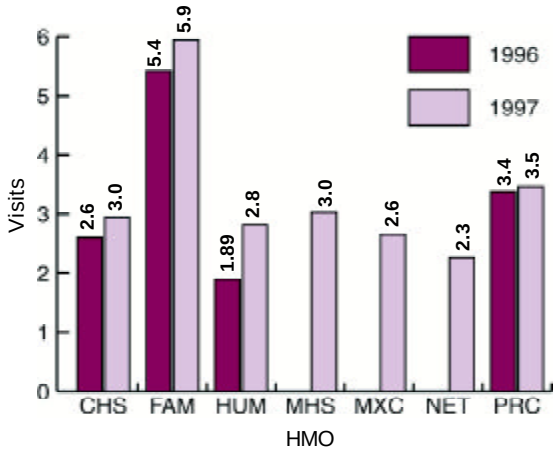
Graph 4.8 shows the number of combined HealthCheck and non-HealthCheck visits for Milwaukee County enrollees in 1996 and 1997. As graph 4.8 illustrates for HMOs that participated in 1996 and 1997, Milwaukee County enrollees had more combined visits in 1997.

Graph 4.7

Number of combined HealthCheck and non-HealthCheck visits per eligible-year, Milwaukee and other counties, ages 0 to 20, 1997

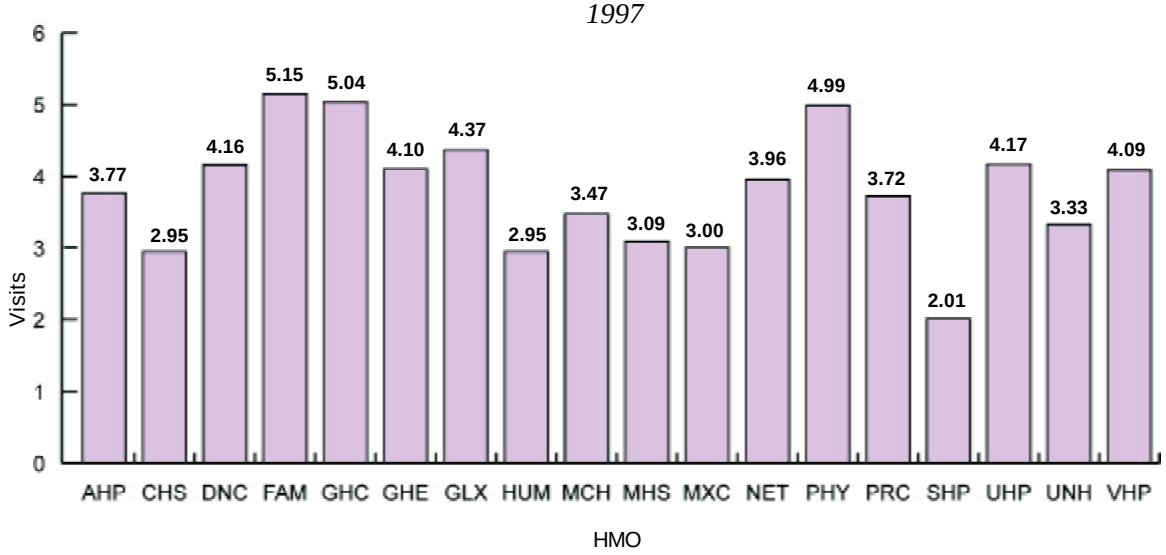
Graph 4.8[2]

Number of combined HealthCheck and non-HealthCheck visits per eligible-year, ages 0-20, Milwaukee County, 1996 and 1997



Graph 4.9

Other counties rate of combined HealthCheck and non-HealthCheck visits per eligible-year, ages 0-20, 1997



Other Counties Combined HealthCheck and Non-HealthCheck Visits

Non-Milwaukee County enrollees receive combined HealthCheck and non-HealthCheck visits ranging from two to five visits per eligible-year. On average the HMOs provide a "medical home" for children with reasonable access to primary care providers as measured by HealthCheck and non-HealthCheck services (Graph 4.9).

Summary

Compared to 1996, the HMOs report small, but consistent, increases in HealthCheck visits per eligible-year provided in 1997. This probably reflects both an increase in actual service provision and improved data reporting.

[1] P.W. Newacheck, J.J. Stoddard, D.C. Hughes, M. Pearl, "Health Insurance and Access to Primary Care For Children." New England Journal of Medicine 1998; 338: 513-518 .

[2] Non-HealthCheck data from Managed Health Services and Maxicare were outliers for 1996 and were not included in this graph nor in the 1996 HMO average. Network Health Plan did not contract for the entire year in 1996 and is not included.

[3] D.S. Canning, J.J. Alpert, H. Bauchner, "Care-Seeking Patterns of Inner-City Families Using an Emergency Room." Medical Care, 1996; 12:117.

Dental Care

Tooth decay is one of the most prevalent preventable chronic diseases of childhood. Facial appearance, self-esteem, the ability to eat and speak, and freedom from dental discomfort all depend heavily on oral health. According to the Centers for Disease Control and Prevention (CDC), 17% of U.S. children will experience tooth decay between two and four years of age.[1] Minority populations and low-income groups are often outside the traditional system of dental care and have the least access to preventive care and treatment services. Among low-income children, up to 80% of tooth decay remains untreated, resulting in pain, dysfunction and altered appearance.

Improving oral health requires repair of dental caries, treatment of dental disease and use of proven preventive strategies. Over the past 50 years much has been accomplished in reducing dental decay through water fluoridation. In Wisconsin, 63% of the population is served by water systems with optimal fluoride content.[2] The majority of dental caries in children occur on tooth surfaces that can be protected by the application of dental sealants.

National Healthy People 2000 goals aimed at preventing dental caries in children include:

- 90% of children age 5 will have visited a dentist in the past year.
- 50% of children ages 8-14 will have dental sealants.

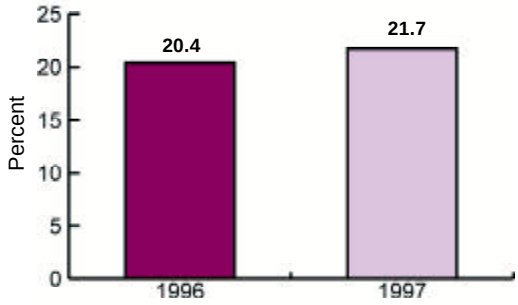
In 1997 Wisconsin Medicaid HMOs were asked to report dental examinations and preventive dental services. Dental activity for only Milwaukee County HMO enrollees is included in this report since the small number of HMOs that elect to provide dental services in other counties makes reporting of utilization data for HMO enrollees in other counties problematic.

Dental Exams – Milwaukee County Enrollees

Dental exams for Milwaukee County enrollees remained relatively stable between 1996 and 1997. (See Graph 4.10) The data reflects dental exams that did not include preventive dental care visits or visits when a sealant was applied.

Graph 4.10

Percent of enrollees receiving dental exams per eligible-year, ages 0-20, Milwaukee County, 1996 and 1997



Preventive Dental Services – Milwaukee County Enrollees

Graph 4.11 shows the percent of eligible recipients receiving preventative dental services per eligible-year for 1996 and 1997 in Milwaukee County HMOs. There was little change between years. The data must be interpreted with caution since it includes all enrollees ages 0–20, but children less than three years old are ordinarily not provided dental care and are unlikely to have a dental visit.

Summary

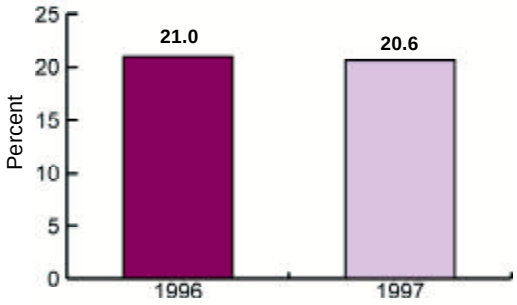
A low rate of dental service delivery is common in most Medicaid programs in the United States. The DHCF is working to encourage provider participation, and to eliminate factors that result in low rates of service utilization by enrollees.

[1] Centers for Disease Control and Prevention. CDC's Oral Health Program. At-A-Glance, 1998.

[2] Wisconsin Public Water Supply Fluoridation Census, 1996.

Graph 4.11

Percent of eligibles receiving preventive dental services per eligible-year, ages 0-20, Milwaukee County, 1996 and 1997



Pap Testing

The purpose of performing cervical cancer screening is to detect precancerous lesions. Detection and treatment of precancerous cervical lesions identified by Pap testing can actually prevent cervical cancer. Over the past several decades there has been a marked decrease in the incidence of invasive cervical cancer. When detected at an early stage, invasive cervical cancer is one of the most successfully treatable cancers, with a 5-year survival rate of 91% for localized cancers.[1]

Still, it is estimated that nationally 13,700 new cases of invasive cervical cancer will be diagnosed in 1998, and 4,900 women will die of the disease.[2]

Cervical cancer is closely linked to sexual behavior and sexually transmitted infections. Women at high risk of developing cervical cancer include females who have first intercourse at an early age, multiple sexual partners, or partners who have had multiple sexual partners.[3]

In 1996, there were 820 new cases of cervical cancer reported to the Wisconsin Cancer Reporting System. Of those reported cases, 80% were in women 20-49 years of age.[4]

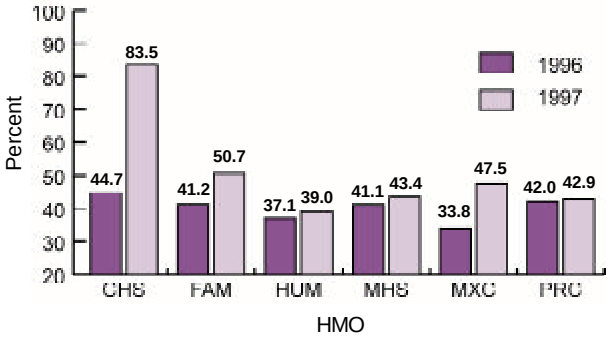
Milwaukee County HMO Pap Testing Rates

The percent of women, ages 15-20, who received a Pap test in Milwaukee County in 1996 and 1997 is displayed in Graph 4.12**.** HMOs with 35 or fewer number of eligible-years were excluded because the numbers were too small to be reliable. The rates in 1997 ranged from 39.0% to 83.5%. In 1997, the percent of eligibles receiving a Pap test per eligible-year for women ages 15-20 served by Milwaukee County HMOs was 51.1% compared to 40.8% in 1996. The increase may be a reflection of improved service and more accurate coding and reporting.

A comparable increase was noted for women 21 and older. In 1996, the rate was 42.9% while the rate was 52.8 % in 1997 (see Graph 4.13).

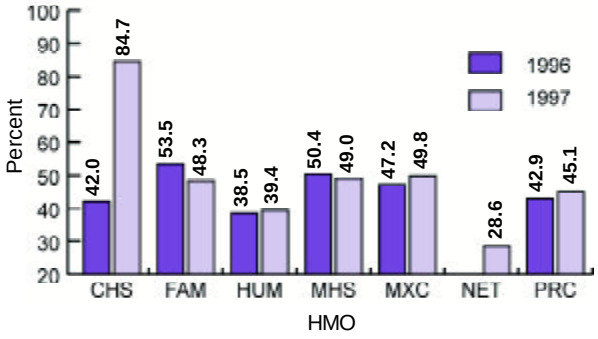
Graph 4.12[5]

Percent of eligibles receiving a Pap test, per eligible-year, Milwaukee County, ages 15-20, 1996 and 1997



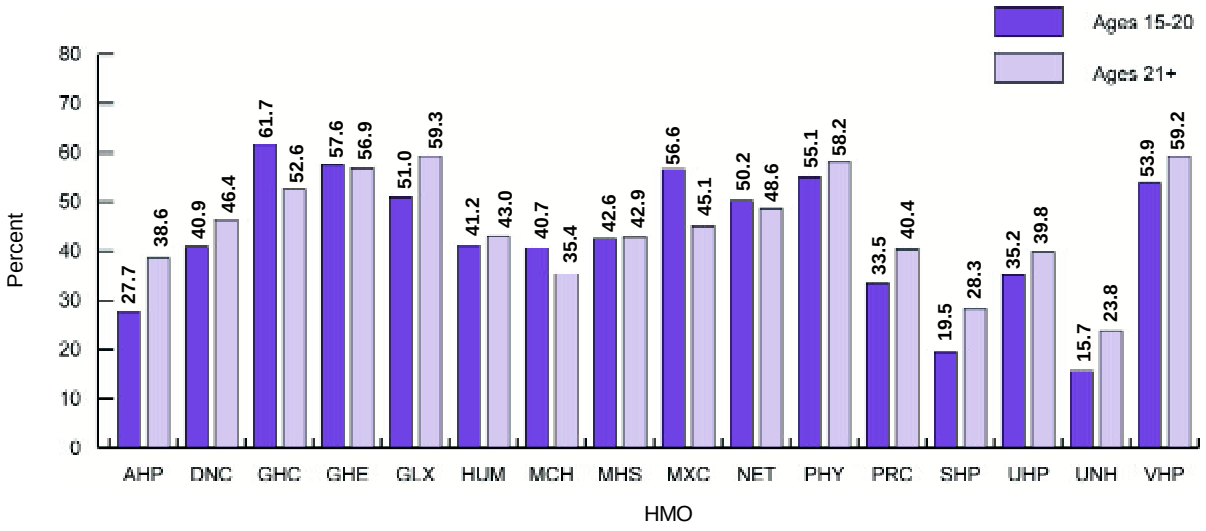
Graph 4.13

Percent of eligibles receiving a Pap test per eligible-year, Milwaukee County, ages 21 and older, 1996 and 1997



Graph 4.14[6]

Percent of eligibles receiving Pap tests per eligible-year for HMOs in other counties, 1997



Other counties HMO Pap Testing Rates

Pap test rates per eligible year for women ages 15-20 served by HMOs in other counties in 1997 ranged from 15.7% to 61.7% with an average of 38.6%. For women ages 21 and older the rates per eligible-year ranged from 23.8% to 59.2% with an average of 42.3% (Graph 4.14).

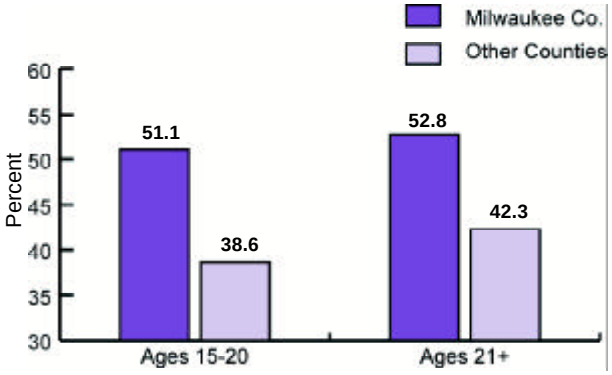
Overall, the Pap test rate for HMOs in Milwaukee County was higher than the rate in other counties (Graph 4.15).

Summary

Overall, there was an increase in Pap testing in 1997 compared to 1996. There was a higher rate of Pap testing both for adolescent and adult women in Milwaukee County than elsewhere.

Graph 4.15[7]

Milwaukee County and other counties HMO Pap test rates per eligible-year, by age group, 1997



[1] American Cancer Society, Cancer Facts and Figures, 1996: Uterus (Cervix) Cancer.

[2] Centers for Disease Control and Prevention. The National Breast and Cervical Cancer Early Detection Program. At-A-Glance, 1998.

[3] American Cancer Society, Cancer Facts and Figures, 1996: Uterus (Cervix) Cancer.

[4] Wisconsin Cancer Incidence and Mortality, 1996. Bureau of Health Information

[5] Network Health Plan is excluded because the number of eligible-years is too small for rates to be statistically valid.

[6] Compcare is excluded as an outlier. Family Health Plan is excluded because the number of eligible-years is too small for rates to be statistically valid.

[7] HMOs with 35 or fewer number of eligible-years were excluded.

Mammography

Excluding skin cancer, breast cancer is the most prevalent and most significant cancer risk among women in the United States. Nationally, it is estimated that 178,700 new cases of breast cancer will be diagnosed in 1998 and 43,900 women will die of the disease.[1] In Wisconsin, breast cancer accounts for over 31% of all female cancer cases. In 1996 there were 3,857 new cases of breast cancer reported to the Wisconsin Cancer Reporting System. Sixty-eight percent of the cases were diagnosed in the early stages while 28% were diagnosed in the more advanced stages. [2]

Mammography is the best way to detect breast cancer in its earliest stages. Mammography detects cancer an average of 1.7 years before it can be felt by a clinical breast examination.[3] Survival rates from breast cancer increase with earlier detection. The five-year national survival rate is 97% when breast cancer is diagnosed when it is localized to the breast.[4]

According to the National Cancer Institute, national statistics for 1994 indicated that white women were more likely to develop breast cancer than African-American women. However, there is a disproportionate number of deaths among women of minority and low-income groups. The incidence of breast cancer increases with age. Nearly 80% of breast cancers occur among women 50 years of age or older.[5]

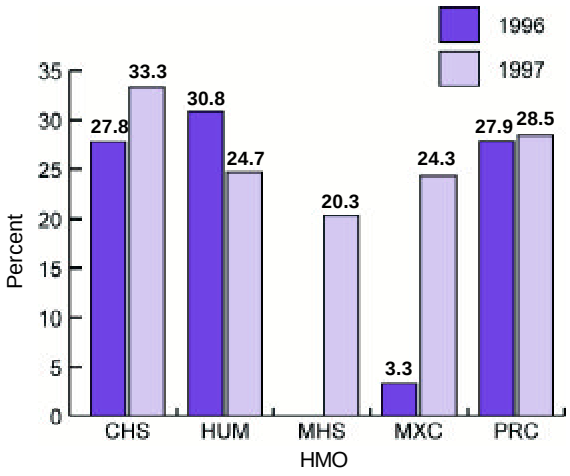
Mammography in Women Age 50 and Over

Comparison of 1997 and 1996 data is very limited due to the small number of female Medicaid recipients over the age of 50. There are only approximately 1,000 female Medicaid recipients served by the HMOs in this age category, with more than half of them being served by Milwaukee County. Therefore, data are not provided for HMOs in other counties.

Data for Milwaukee County HMOs with 35 or fewer eligible-years for women age 50 and over were excluded from Graph 4.16**.** The percent receiving a mammogram per eligible-year for women ages 50 and older in Milwaukee County ranged from 20.3% to 50% with an average of 27.4%. Due to the small number of Medicaid women over age 50, it is difficult to draw conclusions regarding the performance of specific HMOs.

Graph 4.16[6]

Percent of eligibles receiving a mammogram per eligible-year in women ages 50 and older, Milwaukee County, 1996 and 1997



[1] Centers for Disease Control and Prevention. The National Breast and Cervical Cancer Early Detection Program. At-A-Glance, 1998.

[2] Wisconsin Cancer Incidence and Mortality, 1996. Bureau of Health Information.

[3] Centers for Disease Control and Prevention. The National Breast and Cervical Cancer Early Detection Program. At-A-Glance, 1998.

[4] Centers for Disease Control and Prevention. The National Breast and Cervical Cancer Early Detection Program. At-A-Glance, 1998.

[5] Wisconsin Cancer Reporting System, Breast Cancer Information Summary.

[6] FAM for 1996 and 1997 and MHS for 1996 were excluded because the number of eligible-years is too small to be statistically valid.

Emergency Room Visits

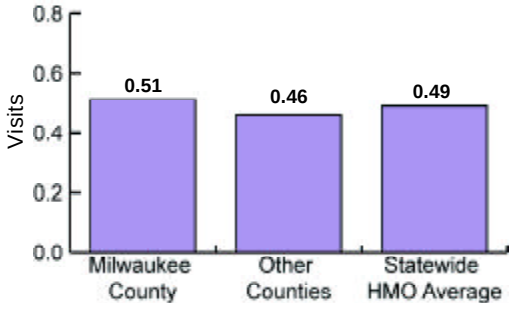
Wisconsin residents visited an emergency room (ER) an estimated 699,000 times in 1996, according to the 1996 Wisconsin Family Health Survey.[1] Emergency room utilization rates based on this self-reported survey were higher for children, the poor, those less educated, and those who were unemployed or children living with unemployed adults. People living in poverty were more likely to have been treated in the ER at least three times in one year.

Emergency Room Visits Without an Admission

An ER visit that is not followed by an admission may indicate a "non-emergency" and represent a health problem that ideally could have been better served by a visit to a primary care doctor if addressed earlier. The reported number of ER visits without an admission per eligible-year in 1997 is nearly identical for HMOs in Milwaukee County and other counties (Graph 4.17).

Graph 4.17

Average number of emergency room visits per eligible-year without admission, all ages, Milwaukee and other counties, 1997

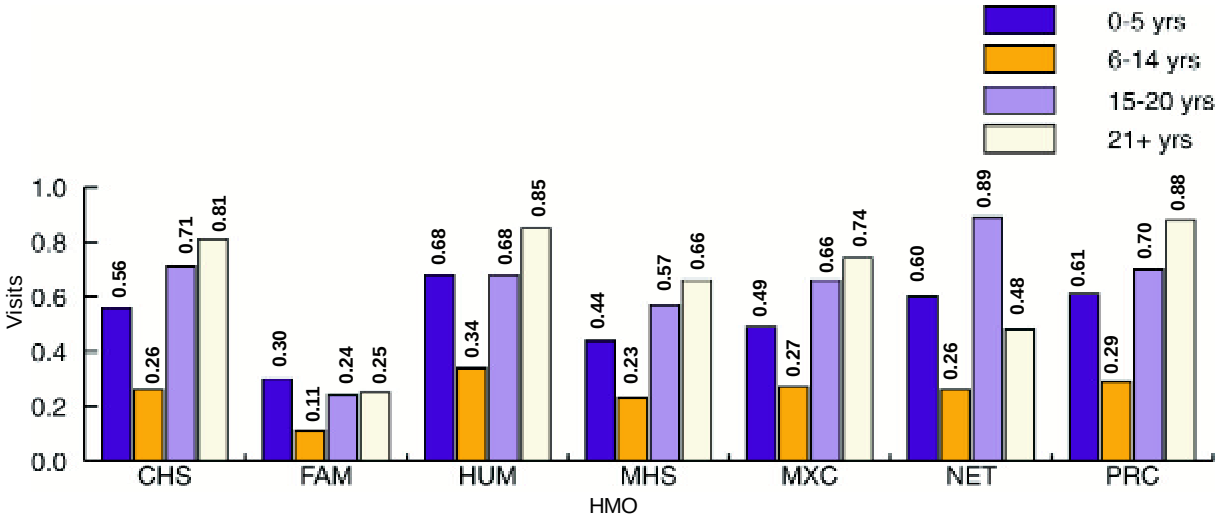


Emergency Room Visits Without Admission by Age Group

Graph 4.18 shows the average number of ER visits without admission per eligible-year for Milwaukee County. Typically, 6- to 14-year-olds had the lowest rate of ER visits, with higher rates for children ages 0-5 years. Rates increased again after age 15.

Graph 4.18

Average number of emergency room visits without admission per eligible-year, by age and HMO, Milwaukee County, 1997



Emergency Room Visits Without Admission – Milwaukee County HMOs

Graph 4.19 shows that each of the Milwaukee County HMOs has a fairly stable rate of ER visits not resulting in admissions per eligible-year. This stability may reflect the long period of time that HMOs in Milwaukee County have participated in Medicaid.

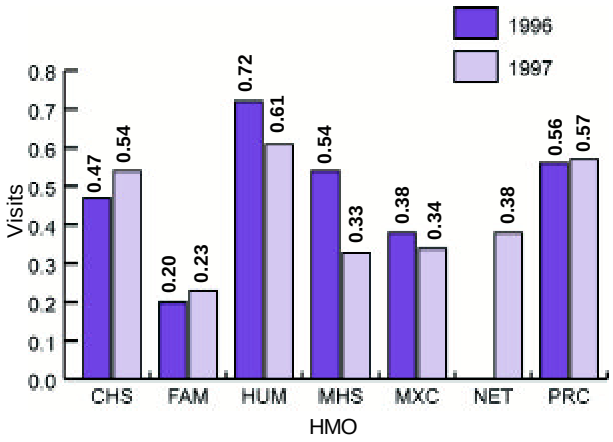
The average number of visits per eligible-year without admission for Milwaukee County HMOs is 0.58.

Emergency room use for enrollees in HMOs in the rest of the state is shown in Graph 4.20**.** The average for this group is 0.46 ER visits without admission per eligible-year. This rate is slightly less than that seen for the Milwaukee County enrollees, suggesting that the rate of ER utilization in the HMOs who are new to Wisconsin Medicaid is not atypical. Emergency room utilization and the availability of primary care provider visits should reflect access to care for non-specialty health care needs.

[1] Wisconsin Family Health Survey 1996, pp 37-39. Bureau of Health Information, Wisconsin Department of Health and Family Services.

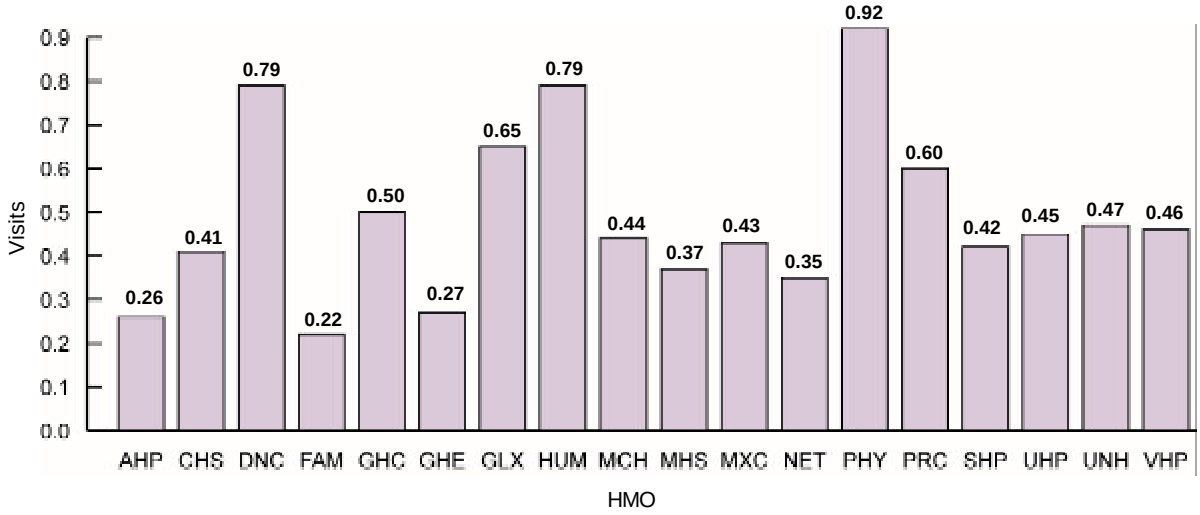
Graph 4.19

Average number of emergency room visits per eligible-year without admission, all ages, Milwaukee County, by HMO, 1996 and 1997



Graph 4.20

Average number of emergency room visits per eligible-year without admission, all ages, other counties, by HMO, 1997



Primary Care Visits

Enrollees who are able to see a primary care provider for routine health care needs should have fewer ER visits. Routine health care needs for such problems as headaches, earaches, and abdominal pain are typically assessed in the primary care provider's office, and only those of a more serious nature would be referred to the ER for evaluation and admission.

Graph 4.21 shows the 1997 HMO average rate of primary care provider visits per eligible-year for all ages is 2.54. The 1996 HMO average for these visits was 2.51. The non-Milwaukee County enrollees had more visits per eligible-year than did the Milwaukee County enrollees.

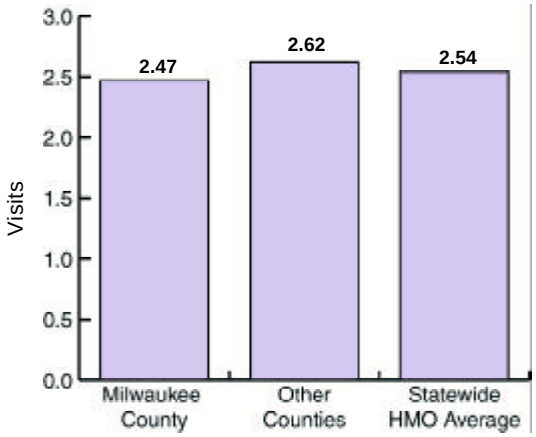
Graph 4.22 shows the primary care visits per eligible-year for the Milwaukee County HMO enrollees. The 1997 average for this group is 2.47 visits per eligible-year, the 1996 average was 2.51 visits per eligible-year. The Milwaukee County enrollees have fairly stable primary care visits and ER visits without admission, suggesting that access for routine care is stable for this group of experienced Wisconsin Medicaid managed care groups. While there is variation in both entities between HMOs, there is a fairly stable intra-HMO environment.

In Graph 4.23, the number of visits per eligible-year for HMO enrollees in the rest of the state is shown to range from 2.07 to 3.47 visits, with an average of 2.62 visits. This average compares favorably with the average of 2.47 visits per eligible-year for the Milwaukee County HMO enrollees.

Again, these figures must be interpreted with the knowledge that, on average, Milwaukee County enrollees were in a single HMO for a longer period of time in 1997 than were the enrollees in other counties HMOs (8.8 months versus 6.8 months. See Table 2.1).

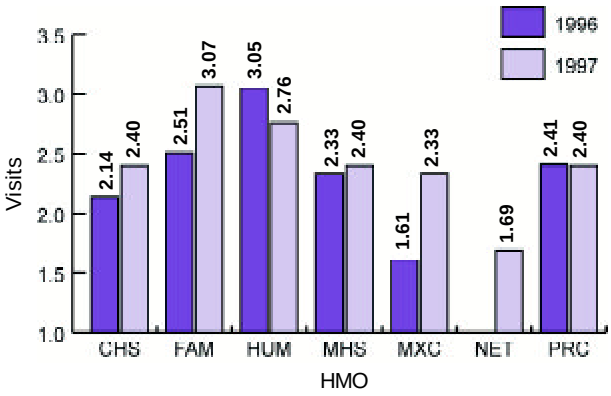
Graph 4.21

Primary care visits per eligible-year, all ages, Milwaukee and other counties, 1997



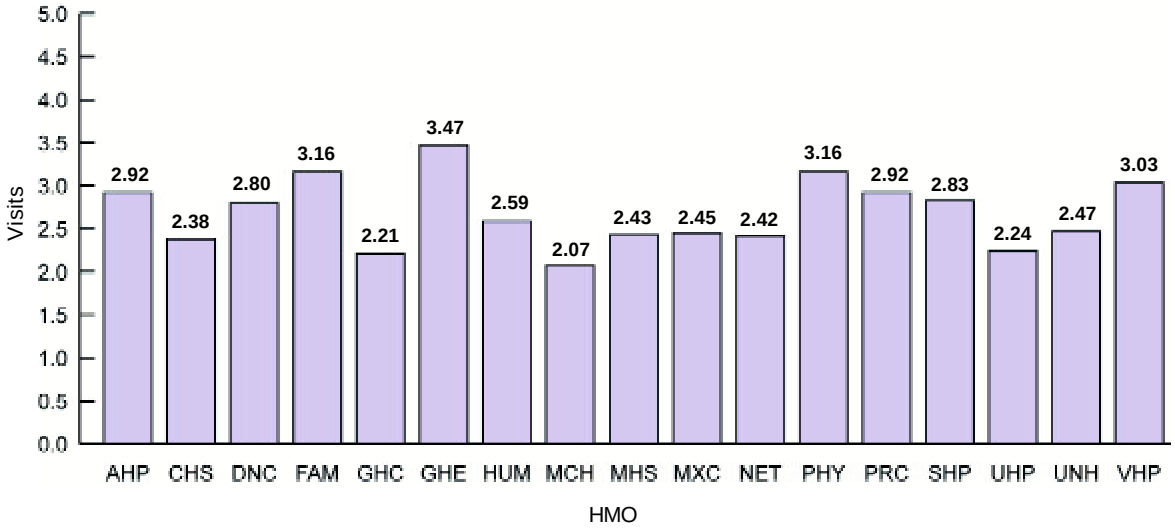
Graph 4.22

Primary care visits per eligible-year, Milwaukee County HMOs, all ages, 1996 and 1997



Graph 4.23

Primary care visits per eligible-year, other counties HMOs, all ages, 1997



Summary

Access to primary care physicians for routine health care appears to be adequate for Wisconsin Medicaid enrollees. Slightly more services are provided for non-Milwaukee County enrollees. At the same time, there is no evidence that ER visits without admission have increased within any specific HMO.

Section 4

Access and Service

The Medicaid Aid to Families with Dependent Children (AFDC)/Healthy Start population represents a young, predominately female segment of the Wisconsin population. Services that are important in promoting and maintaining health for this group of Medicaid recipients include wellness checks for children, routine office care for all age groups, preventive dental care for children, Pap tests, mammography, and access to required emergency care.

HealthCheck is the service Wisconsin Medicaid provides to promote and maintain the health of children. Routine office care is measured by non-HealthCheck visits for all age groups. Routine office visits estimate the ease with which this population is able to access routine and acute care through a "medical home."

Preventive dental services for children are especially important to prevent poor dental function as the child matures. Timely, adequate preventive dental services are cost-effective in preventing significant dental malfunction, and the attendant unwanted health care issues.

Pap testing is especially important in early detection and treatment of cervical cancer. At the same time, routine examination will permit early detection of related gynecologic problems before serious, and permanent, health concerns arise. Mammography is meaningful to this population even though most Medicaid enrollees are significantly younger than the general population. The ability to detect breast lesions early increases the efficacy of treatment.

Emergency care is a vital component of services provided to any group of health care recipients. The availability and use of emergency medical care may be used to measure enrollees' ease of access to routine and acute care through their HMOs, or the establishment of a "medical home." A "medical home" should permit enrollees to use emergency care in the most cost-effective manner.

HealthCheck Visits

Components of HealthCheck Visits

Well-child assessments are an essential component in meeting preventive health care needs of children enrolled in Wisconsin Medicaid. In Wisconsin, federally prescribed well-child assessments are called HealthChecks.[1] HealthCheck permits providers to evaluate a child's physical, cognitive, social, and emotional development, identify preventable problems, screen for potential risk factors, provide appropriate immunizations and make referrals to providers and health care agencies to meet the child's health needs. Children ages 3 and older are referred for preventive and necessary dental care. HealthCheck also provides an opportunity for identifying children at risk for elevated lead blood levels, neglect, abuse, and dietary problems, as well as provide an opportunity for teaching and counseling parents.

Frequency of HealthCheck Visits

The schedule of periodic exams adopted for HealthCheck is based on recommendations by the American Academy of Pediatrics (AAP). A total of 12 HealthCheck exams are recommended to be given by the time a child reaches the age of 6. The goal of the Wisconsin Department of Health and Family Services (DHFS) for the year 2000 is "to increase to 90% the proportion of children aged birth through 5 years who receive well-child assessments through a HealthCheck exam."[2]

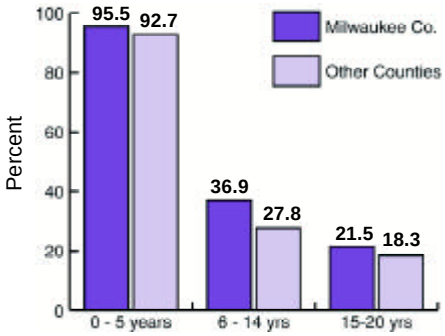
1997 HealthCheck Services

HealthCheck visits are especially important in the first years of life to ensure that children receive timely assessments to avoid medical conditions that could have long-term consequences if they do not receive early attention.

The percent of eligibles screened per eligible-year for children ages 0-5 years in 1996 was approximately 80%. The 1997 percent of eligibles screened per eligible-year, for the same age group, was approximately 94%. This probably reflects both an increase in services delivered and increased administrative efficiency in reporting.

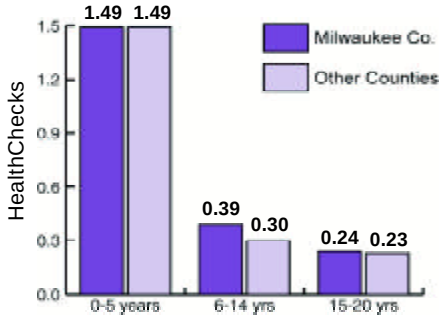
Graph 4.1

Percent of eligibles receiving a HealthCheck screen per eligible-year, by age, Milwaukee and other counties, 1997



Graph 4.2

Number of HealthCheck visits per eligible-year, by age, Milwaukee and other counties, 1997



The HMOs provide more HealthCheck services per eligible-year for preschool age children. The HealthCheck recommendations support a greater intensity of HealthCheck services within the early years of life. Graph 4.1 shows that HMOs deliver a greater intensity of HealthCheck visits per eligible recipient in the preschool years, consistent with the following federal reporting recommendations. Graph 4.2 shows a comparable number of HealthCheck visits per eligible-year for Milwaukee County and other counties.

Federal reporting recommendations include six HealthCheck visits within the first year, and 1.2 visits per year for children ages 1 to 5 years. This translates to two visits per year for children ages 0 to 5. This compares to the reported all-HMO average of 1.5 HealthCheck visits per eligible-year for the 0- to 5-year-old age group. These data do not include those HealthCheck visits obtained at public health clinics that were not billed to the member's HMO.

The 1997 average of 1.5 HealthCheck visits per eligible-year for children ages 0–5 is greater than the 1996 HMO average of 1.36 for the same age group.

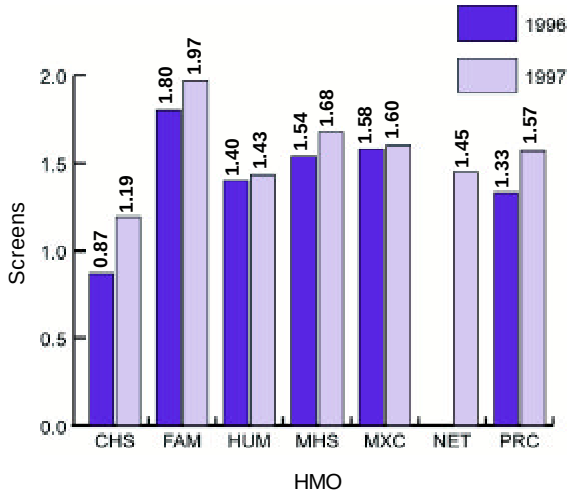
Federal reporting requirements for ages 6–14 and ages 15–20 are 0.56 visits and 0.50 visits per year, respectively. This compares to the Wisconsin Medicaid HMOs provision of 0.35 visits per eligible-year to the 6–14 year-old age group, and 0.23 visits per eligible-year to the 15–20 year-old age group. Again, this number does not include visits which may have occurred related to non-HealthCheck visits, or services provided by public agencies who do not bill the member's HMO.

Milwaukee County HMOs

The number of HealthCheck screens per eligible-year for children ages 0-5 in Milwaukee County for 1996 and 1997 is presented in Graph 4.3. All HMOs that participated in Medicaid for both years increased the number of screens per eligible-year, with the average increasing from 1.35 in 1996 to 1.49 in 1997.

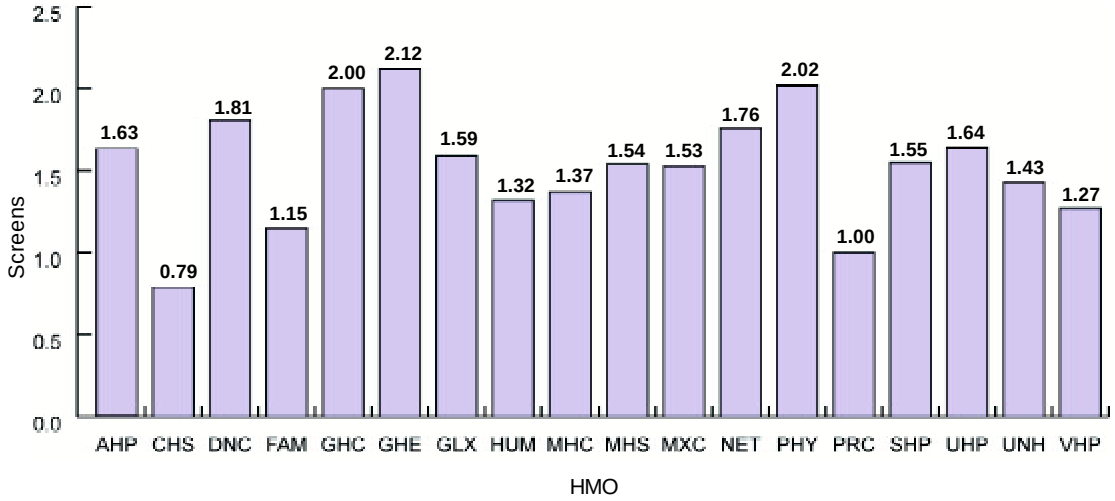
Graph 4.3

Average number of HealthCheck screens per eligible-year for Milwaukee County, ages 0-5, 1996 and 1997



Graph 4.4

Average number of HealthCheck screens per eligible-year for other counties, ages 0-5, 1997



Other County HMOs

The number of HealthCheck screens per eligible-year for children ages 0-5 in other counties is presented in Graph 4.4. The HealthCheck visits ranged from less than one visit per eligible-year to over two visits per eligible-year. For HMOs in the rest of the state, the HealthCheck services average was 1.49 visits per eligible-year, which is identical to the Milwaukee County average.

Summary

In Wisconsin Medicaid HMOs, approximately 94% of eligibles are screened per eligible-year through HealthCheck services at an early age (0–5 years). The percent of children who received a HealthCheck service and the rate of screening were higher in 1997 than 1996. The recommended frequency of HealthCheck visits per eligible-year is less as the child enters the school years and into early adulthood. The rate of HealthCheck services shown in this report follows that pattern, but may also be a reflection of services provided by the school that are not reported to the HMOs.

[1] A comprehensive HealthCheck screen includes:

- A comprehensive health and developmental history.
- A comprehensive physical exam.
- Appropriate immunizations.
- Laboratory tests (including blood lead screening and testing).
- Vision screening.
- Hearing screening.
- Oral assessment and referral to dentist at age 3.

[2] Strategic business plan: Department of Health and Family Services, 1996-2001. September, 1996.

HealthCheck and Non-HealthCheck Visits

Access to Care

Non-HealthCheck visit utilization data very likely measure non-preventive care visits received by children enrolled in AFDC/Healthy Start Medicaid. As such, these visits are an indication of the ease with which children receive routine and acute care. The availability of non-HealthCheck visits helps establish a primary care "medical home" for children enrolled in the AFDC/Healthy Start Medicaid program. The availability of primary care is essential to children's well-being. The AAP defines primary care as "accessible and affordable, first contact, continuous and comprehensive, and coordinated to meet the health needs of the individual and family being served."[1]

Non-HealthCheck Visits per Eligible-Year – Milwaukee County and Non-Milwaukee County

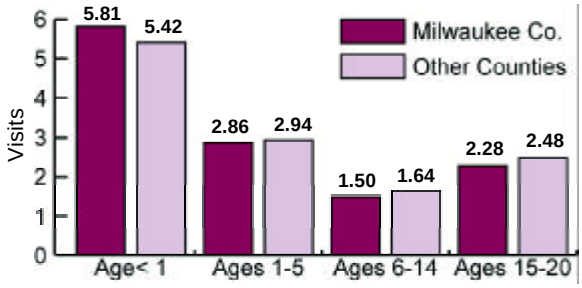
Graph 4.5 shows that the non-Milwaukee County HMOs delivered slightly more non-Health Check visits than did the Milwaukee County HMOs, with the exception of the less than one-year-old group of recipients. All the HMOs provided an average of 2.57 visits per eligible-year for ages 0-20, compared to an average of 2.4 non-HealthCheck visits per eligible-year in 1996. This increase may reflect increased provider services and administrative efficiency and data reporting stimulated by Division of Health Care Financing (DHCF) data validity audits and technical assistance.

Milwaukee County Non-HealthCheck Visits[2]

Graph 4.6 shows the average number of non-HealthCheck visits per eligible-year for Milwaukee County HMOs in 1996 and 1997. There was a slight rise in the number of non-HealthCheck visits for the entire age group 0-20 years from 1996 to 1997.

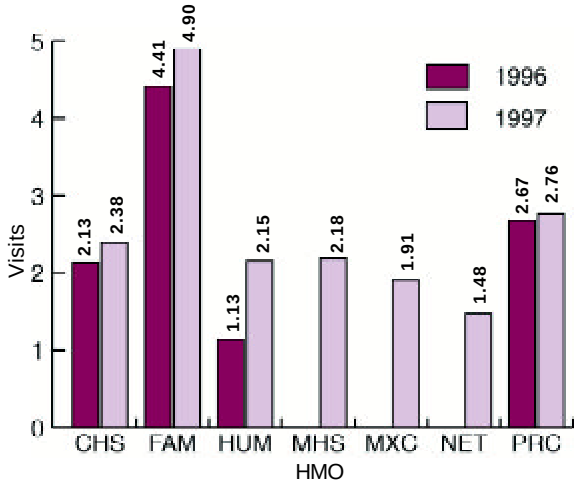
Graph 4.5

Number of non-HealthCheck visits per eligible-year by ages, Milwaukee and other counties, 1997



Graph 4.6[2]

Number of non-HealthCheck visits per eligible-year, other counties, ages 0-20, 1996 and 1997



Combined HealthCheck and Non-HealthCheck Visits – Milwaukee County and Other Counties

In 1996, the HMOs provided an average of 3.1 combined HealthCheck and non-HealthCheck visits per enrollee, per eligible-year. In 1997 the number was 3.3 visits. When all visits are combined, the Milwaukee County HMOs provided slightly fewer services per eligible-year than the other counties HMOs in the rest of the state (Graph 4.7).

The number of enrollee visits per eligible-year is an indicator of an HMO's ability to deliver primary care services to enrolled children. Taken in conjunction with the number of enrollee emergency room visits per eligible-year, this information may be useful in estimating the availability of primary care providers to see enrollees for acute problems.[3]

Milwaukee County Combined HealthCheck and Non-HealthCheck Visits

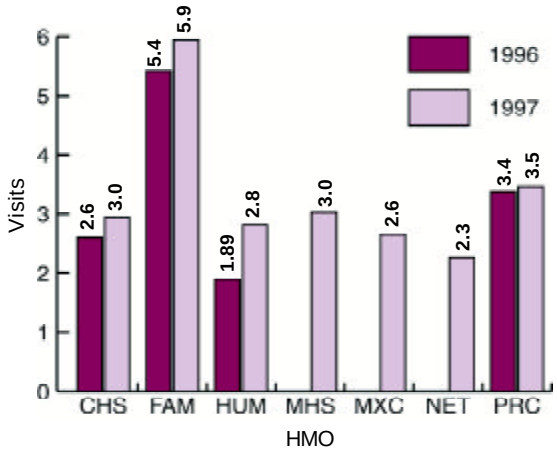
Graph 4.8 shows the number of combined HealthCheck and non-HealthCheck visits for Milwaukee County enrollees in 1996 and 1997. As graph 4.8 illustrates for HMOs that participated in 1996 and 1997, Milwaukee County enrollees had more combined visits in 1997.

Graph 4.7

Number of combined HealthCheck and non-HealthCheck visits per eligible-year, Milwaukee and other counties, ages 0 to 20, 1997

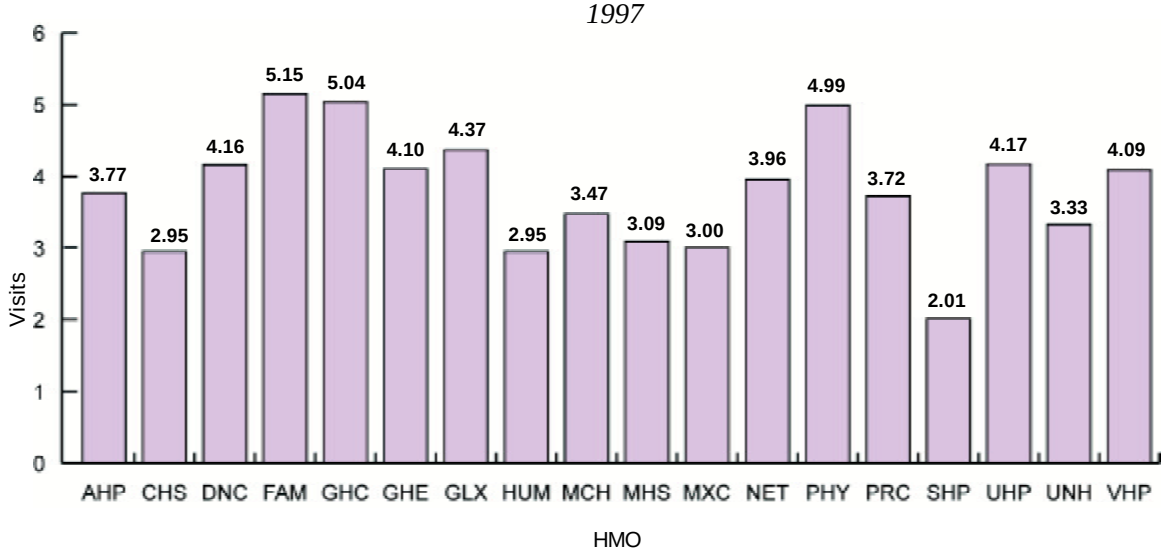
Graph 4.8[2]

Number of combined HealthCheck and non-HealthCheck visits per eligible-year, ages 0-20, Milwaukee County, 1996 and 1997



Graph 4.9

Other counties rate of combined HealthCheck and non-HealthCheck visits per eligible-year, ages 0-20, 1997



Other Counties Combined HealthCheck and Non-HealthCheck Visits

Non-Milwaukee County enrollees receive combined HealthCheck and non-HealthCheck visits ranging from two to five visits per eligible-year. On average the HMOs provide a "medical home" for children with reasonable access to primary care providers as measured by HealthCheck and non-HealthCheck services (Graph 4.9).

Summary

Compared to 1996, the HMOs report small, but consistent, increases in HealthCheck visits per eligible-year provided in 1997. This probably reflects both an increase in actual service provision and improved data reporting.

[1] P.W. Newacheck, J.J. Stoddard, D.C. Hughes, M. Pearl, "Health Insurance and Access to Primary Care For Children." New England Journal of Medicine 1998; 338: 513-518 .

[2] Non-HealthCheck data from Managed Health Services and Maxicare were outliers for 1996 and were not included in this graph nor in the 1996 HMO average. Network Health Plan did not contract for the entire year in 1996 and is not included.

[3] D.S. Canning, J.J. Alpert, H. Bauchner, "Care-Seeking Patterns of Inner-City Families Using an Emergency Room." Medical Care, 1996; 12:117.

Dental Care

Tooth decay is one of the most prevalent preventable chronic diseases of childhood. Facial appearance, self-esteem, the ability to eat and speak, and freedom from dental discomfort all depend heavily on oral health. According to the Centers for Disease Control and Prevention (CDC), 17% of U.S. children will experience tooth decay between two and four years of age.[1] Minority populations and low-income groups are often outside the traditional system of dental care and have the least access to preventive care and treatment services. Among low-income children, up to 80% of tooth decay remains untreated, resulting in pain, dysfunction and altered appearance.

Improving oral health requires repair of dental caries, treatment of dental disease and use of proven preventive strategies. Over the past 50 years much has been accomplished in reducing dental decay through water fluoridation. In Wisconsin, 63% of the population is served by water systems with optimal fluoride content.[2] The majority of dental caries in children occur on tooth surfaces that can be protected by the application of dental sealants.

National Healthy People 2000 goals aimed at preventing dental caries in children include:

- 90% of children age 5 will have visited a dentist in the past year.
- 50% of children ages 8-14 will have dental sealants.

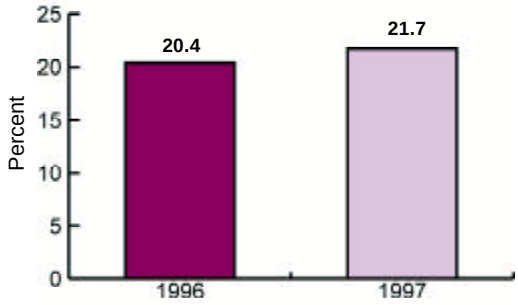
In 1997 Wisconsin Medicaid HMOs were asked to report dental examinations and preventive dental services. Dental activity for only Milwaukee County HMO enrollees is included in this report since the small number of HMOs that elect to provide dental services in other counties makes reporting of utilization data for HMO enrollees in other counties problematic.

Dental Exams – Milwaukee County Enrollees

Dental exams for Milwaukee County enrollees remained relatively stable between 1996 and 1997. (See Graph 4.10) The data reflects dental exams that did not include preventive dental care visits or visits when a sealant was applied.

Graph 4.10

Percent of enrollees receiving dental exams per eligible-year, ages 0-20, Milwaukee County, 1996 and 1997



Preventive Dental Services – Milwaukee County Enrollees

Graph 4.11 shows the percent of eligible recipients receiving preventative dental services per eligible-year for 1996 and 1997 in Milwaukee County HMOs. There was little change between years. The data must be interpreted with caution since it includes all enrollees ages 0–20, but children less than three years old are ordinarily not provided dental care and are unlikely to have a dental visit.

Summary

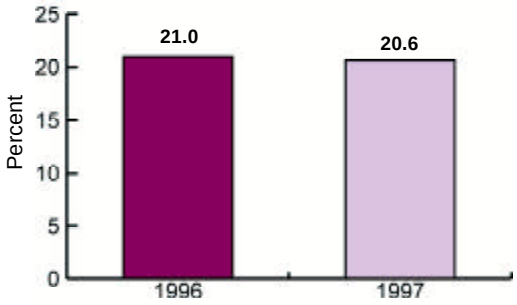
A low rate of dental service delivery is common in most Medicaid programs in the United States. The DHCF is working to encourage provider participation, and to eliminate factors that result in low rates of service utilization by enrollees.

[1] Centers for Disease Control and Prevention. CDC's Oral Health Program. At-A-Glance, 1998.

[2] Wisconsin Public Water Supply Fluoridation Census, 1996.

Graph 4.11

Percent of eligibles receiving preventive dental services per eligible-year, ages 0-20, Milwaukee County, 1996 and 1997



Pap Testing

The purpose of performing cervical cancer screening is to detect precancerous lesions. Detection and treatment of precancerous cervical lesions identified by Pap testing can actually prevent cervical cancer. Over the past several decades there has been a marked decrease in the incidence of invasive cervical cancer. When detected at an early stage, invasive cervical cancer is one of the most successfully treatable cancers, with a 5-year survival rate of 91% for localized cancers.[1]

Still, it is estimated that nationally 13,700 new cases of invasive cervical cancer will be diagnosed in 1998, and 4,900 women will die of the disease.[2]

Cervical cancer is closely linked to sexual behavior and sexually transmitted infections. Women at high risk of developing cervical cancer include females who have first intercourse at an early age, multiple sexual partners, or partners who have had multiple sexual partners.[3]

In 1996, there were 820 new cases of cervical cancer reported to the Wisconsin Cancer Reporting System. Of those reported cases, 80% were in women 20-49 years of age.[4]

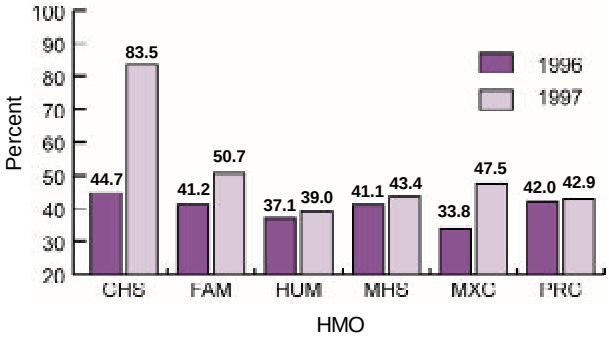
Milwaukee County HMO Pap Testing Rates

The percent of women, ages 15-20, who received a Pap test in Milwaukee County in 1996 and 1997 is displayed in Graph 4.12**.** HMOs with 35 or fewer number of eligible-years were excluded because the numbers were too small to be reliable. The rates in 1997 ranged from 39.0% to 83.5%. In 1997, the percent of eligibles receiving a Pap test per eligible-year for women ages 15-20 served by Milwaukee County HMOs was 51.1% compared to 40.8% in 1996. The increase may be a reflection of improved service and more accurate coding and reporting.

A comparable increase was noted for women 21 and older. In 1996, the rate was 42.9% while the rate was 52.8 % in 1997 (see Graph 4.13).

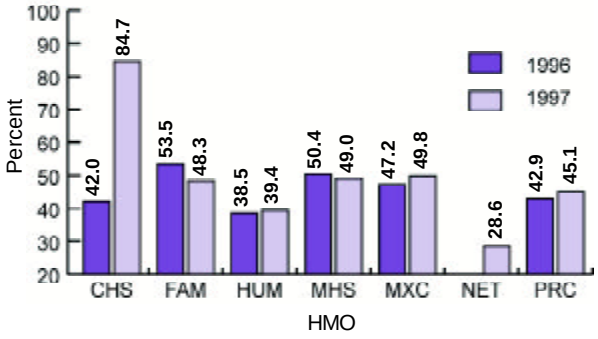
Graph 4.12[5]

Percent of eligibles receiving a Pap test, per eligible-year, Milwaukee County, ages 15-20, 1996 and 1997



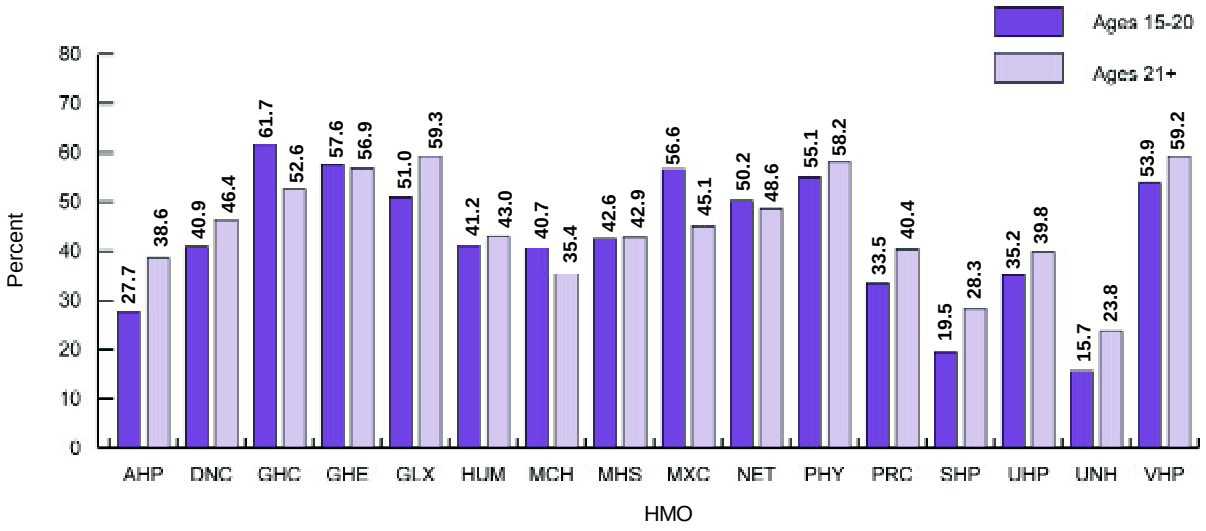
Graph 4.13

Percent of eligibles receiving a Pap test per eligible-year, Milwaukee County, ages 21 and older, 1996 and 1997



Graph 4.14[6]

Percent of eligibles receiving Pap tests per eligible-year for HMOs in other counties, 1997



Other counties HMO Pap Testing Rates

Pap test rates per eligible year for women ages 15-20 served by HMOs in other counties in 1997 ranged from 15.7% to 61.7% with an average of 38.6%. For women ages 21 and older the rates per eligible-year ranged from 23.8% to 59.2% with an average of 42.3% (Graph 4.14).

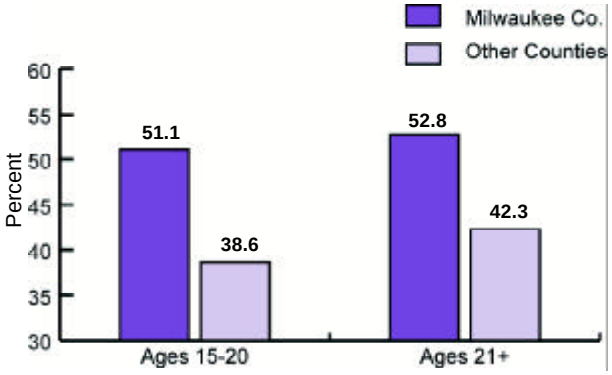
Overall, the Pap test rate for HMOs in Milwaukee County was higher than the rate in other counties (Graph 4.15).

Summary

Overall, there was an increase in Pap testing in 1997 compared to 1996. There was a higher rate of Pap testing both for adolescent and adult women in Milwaukee County than elsewhere.

Graph 4.15[7]

Milwaukee County and other counties HMO Pap test rates per eligible-year, by age group, 1997



[1] American Cancer Society, Cancer Facts and Figures, 1996: Uterus (Cervix) Cancer.

[2] Centers for Disease Control and Prevention. The National Breast and Cervical Cancer Early Detection Program. At-A-Glance, 1998.

[3] American Cancer Society, Cancer Facts and Figures, 1996: Uterus (Cervix) Cancer.

[4] Wisconsin Cancer Incidence and Mortality, 1996. Bureau of Health Information

[5] Network Health Plan is excluded because the number of eligible-years is too small for rates to be statistically valid.

[6] Compcare is excluded as an outlier. Family Health Plan is excluded because the number of eligible-years is too small for rates to be statistically valid.

[7] HMOs with 35 or fewer number of eligible-years were excluded.

Mammography

Excluding skin cancer, breast cancer is the most prevalent and most significant cancer risk among women in the United States. Nationally, it is estimated that 178,700 new cases of breast cancer will be diagnosed in 1998 and 43,900 women will die of the disease.[1] In Wisconsin, breast cancer accounts for over 31% of all female cancer cases. In 1996 there were 3,857 new cases of breast cancer reported to the Wisconsin Cancer Reporting System. Sixty-eight percent of the cases were diagnosed in the early stages while 28% were diagnosed in the more advanced stages. [2]

Mammography is the best way to detect breast cancer in its earliest stages. Mammography detects cancer an average of 1.7 years before it can be felt by a clinical breast examination.[3] Survival rates from breast cancer increase with earlier detection. The five-year national survival rate is 97% when breast cancer is diagnosed when it is localized to the breast.[4]

According to the National Cancer Institute, national statistics for 1994 indicated that white women were more likely to develop breast cancer than African-American women. However, there is a disproportionate number of deaths among women of minority and low-income groups. The incidence of breast cancer increases with age. Nearly 80% of breast cancers occur among women 50 years of age or older.[5]

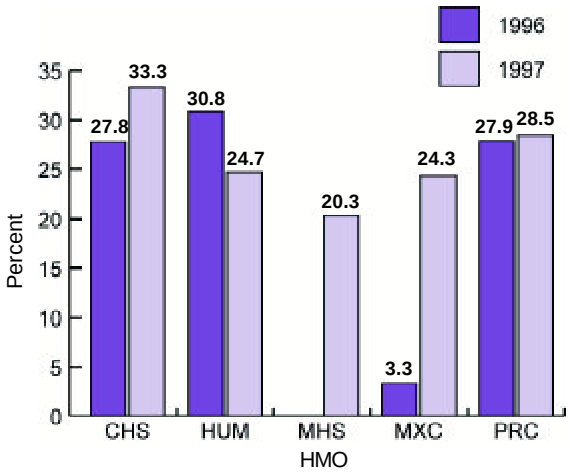
Mammography in Women Age 50 and Over

Comparison of 1997 and 1996 data is very limited due to the small number of female Medicaid recipients over the age of 50. There are only approximately 1,000 female Medicaid recipients served by the HMOs in this age category, with more than half of them being served by Milwaukee County. Therefore, data are not provided for HMOs in other counties.

Data for Milwaukee County HMOs with 35 or fewer eligible-years for women age 50 and over were excluded from Graph 4.16**.** The percent receiving a mammogram per eligible-year for women ages 50 and older in Milwaukee County ranged from 20.3% to 50% with an average of 27.4%. Due to the small number of Medicaid women over age 50, it is difficult to draw conclusions regarding the performance of specific HMOs.

Graph 4.16[6]

Percent of eligibles receiving a mammogram per eligible-year in women ages 50 and older, Milwaukee County, 1996 and 1997



[1] Centers for Disease Control and Prevention. The National Breast and Cervical Cancer Early Detection Program. At-A-Glance, 1998.

[2] Wisconsin Cancer Incidence and Mortality, 1996. Bureau of Health Information.

[3] Centers for Disease Control and Prevention. The National Breast and Cervical Cancer Early Detection Program. At-A-Glance, 1998.

[4] Centers for Disease Control and Prevention. The National Breast and Cervical Cancer Early Detection Program. At-A-Glance, 1998.

[5] Wisconsin Cancer Reporting System, Breast Cancer Information Summary.

[6] FAM for 1996 and 1997 and MHS for 1996 were excluded because the number of eligible-years is too small to be statistically valid.

Emergency Room Visits

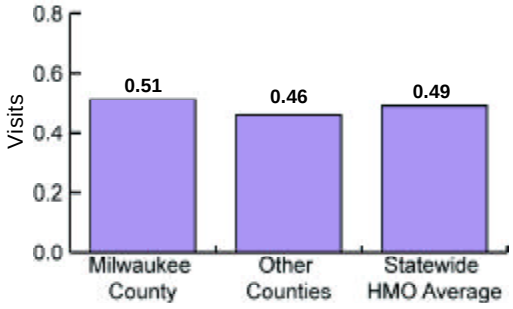
Wisconsin residents visited an emergency room (ER) an estimated 699,000 times in 1996, according to the 1996 Wisconsin Family Health Survey.[1] Emergency room utilization rates based on this self-reported survey were higher for children, the poor, those less educated, and those who were unemployed or children living with unemployed adults. People living in poverty were more likely to have been treated in the ER at least three times in one year.

Emergency Room Visits Without an Admission

An ER visit that is not followed by an admission may indicate a "non-emergency" and represent a health problem that ideally could have been better served by a visit to a primary care doctor if addressed earlier. The reported number of ER visits without an admission per eligible-year in 1997 is nearly identical for HMOs in Milwaukee County and other counties (Graph 4.17).

Graph 4.17

Average number of emergency room visits per eligible-year without admission, all ages, Milwaukee and other counties, 1997

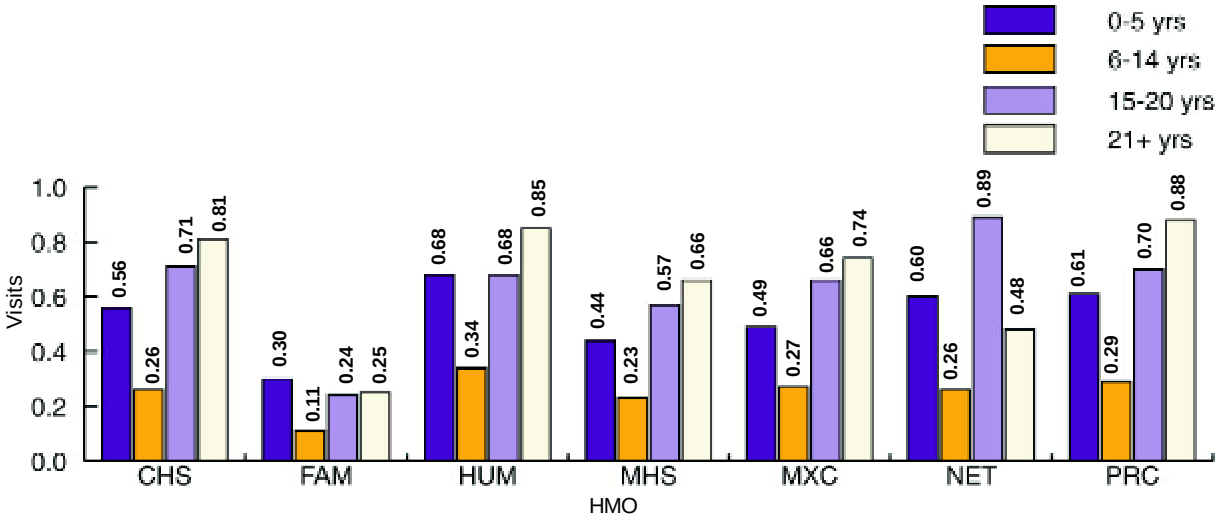


Emergency Room Visits Without Admission by Age Group

Graph 4.18 shows the average number of ER visits without admission per eligible-year for Milwaukee County. Typically, 6- to 14-year-olds had the lowest rate of ER visits, with higher rates for children ages 0-5 years. Rates increased again after age 15.

Graph 4.18

Average number of emergency room visits without admission per eligible-year, by age and HMO, Milwaukee County, 1997



Emergency Room Visits Without Admission – Milwaukee County HMOs

Graph 4.19 shows that each of the Milwaukee County HMOs has a fairly stable rate of ER visits not resulting in admissions per eligible-year. This stability may reflect the long period of time that HMOs in Milwaukee County have participated in Medicaid.

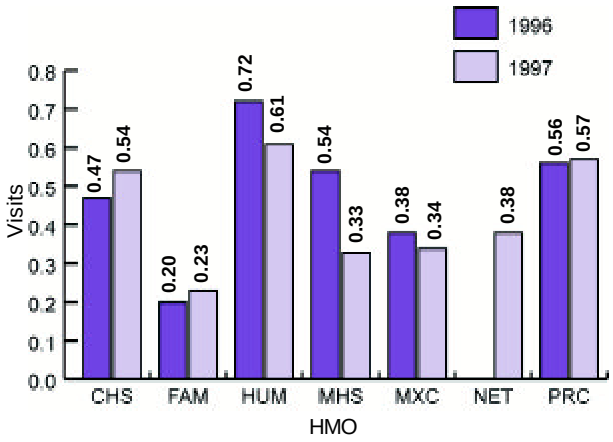
The average number of visits per eligible-year without admission for Milwaukee County HMOs is 0.58.

Emergency room use for enrollees in HMOs in the rest of the state is shown in Graph 4.20**.** The average for this group is 0.46 ER visits without admission per eligible-year. This rate is slightly less than that seen for the Milwaukee County enrollees, suggesting that the rate of ER utilization in the HMOs who are new to Wisconsin Medicaid is not atypical. Emergency room utilization and the availability of primary care provider visits should reflect access to care for non-specialty health care needs.

[1] Wisconsin Family Health Survey 1996, pp 37-39. Bureau of Health Information, Wisconsin Department of Health and Family Services.

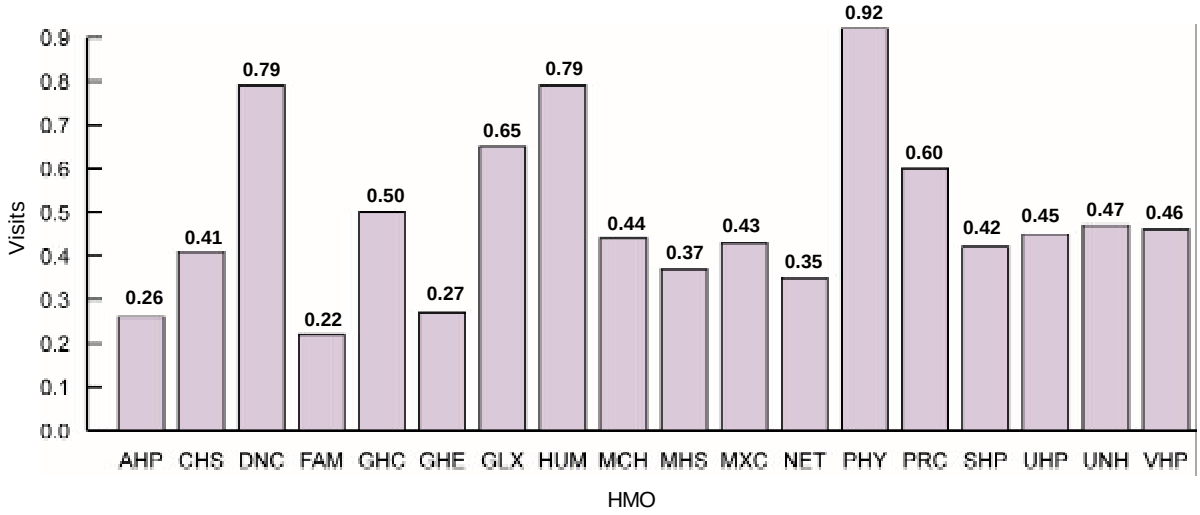
Graph 4.19

Average number of emergency room visits per eligible-year without admission, all ages, Milwaukee County, by HMO, 1996 and 1997



Graph 4.20

Average number of emergency room visits per eligible-year without admission, all ages, other counties, by HMO, 1997



Primary Care Visits

Enrollees who are able to see a primary care provider for routine health care needs should have fewer ER visits. Routine health care needs for such problems as headaches, earaches, and abdominal pain are typically assessed in the primary care provider's office, and only those of a more serious nature would be referred to the ER for evaluation and admission.

Graph 4.21 shows the 1997 HMO average rate of primary care provider visits per eligible-year for all ages is 2.54. The 1996 HMO average for these visits was 2.51. The non-Milwaukee County enrollees had more visits per eligible-year than did the Milwaukee County enrollees.

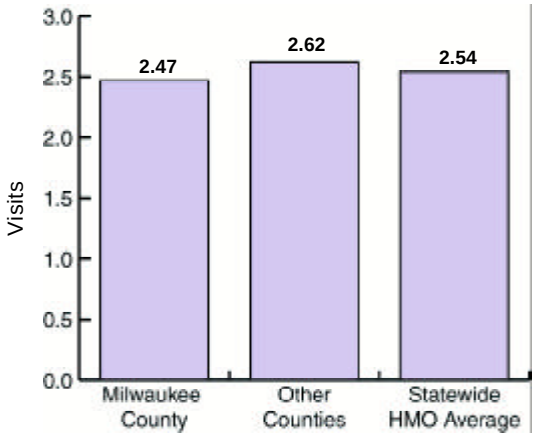
Graph 4.22 shows the primary care visits per eligible-year for the Milwaukee County HMO enrollees. The 1997 average for this group is 2.47 visits per eligible-year, the 1996 average was 2.51 visits per eligible-year. The Milwaukee County enrollees have fairly stable primary care visits and ER visits without admission, suggesting that access for routine care is stable for this group of experienced Wisconsin Medicaid managed care groups. While there is variation in both entities between HMOs, there is a fairly stable intra-HMO environment.

In Graph 4.23, the number of visits per eligible-year for HMO enrollees in the rest of the state is shown to range from 2.07 to 3.47 visits, with an average of 2.62 visits. This average compares favorably with the average of 2.47 visits per eligible-year for the Milwaukee County HMO enrollees.

Again, these figures must be interpreted with the knowledge that, on average, Milwaukee County enrollees were in a single HMO for a longer period of time in 1997 than were the enrollees in other counties HMOs (8.8 months versus 6.8 months. See Table 2.1).

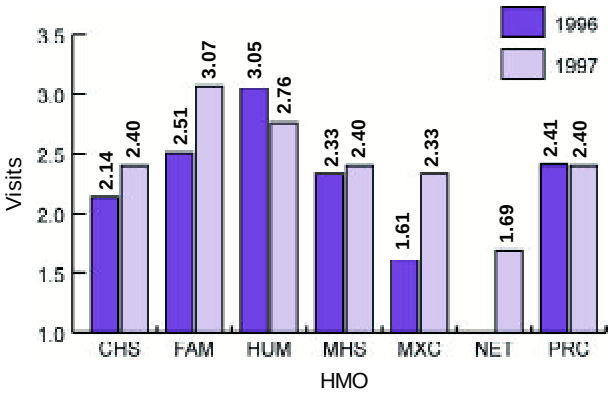
Graph 4.21

Primary care visits per eligible-year, all ages, Milwaukee and other counties, 1997



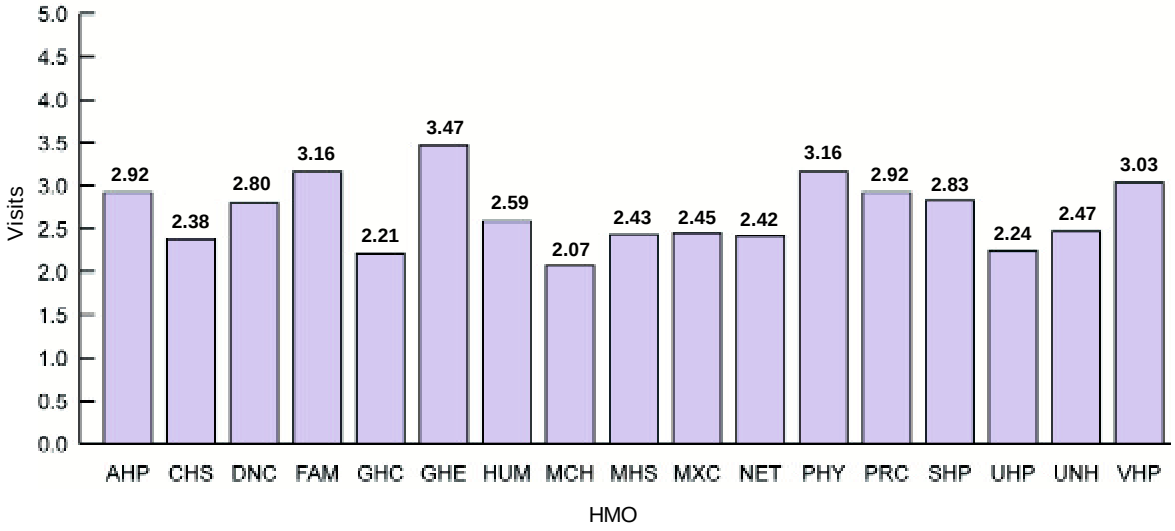
Graph 4.22

Primary care visits per eligible-year, Milwaukee County HMOs, all ages, 1996 and 1997



Graph 4.23

Primary care visits per eligible-year, other counties HMOs, all ages, 1997



Summary

Access to primary care physicians for routine health care appears to be adequate for Wisconsin Medicaid enrollees. Slightly more services are provided for non-Milwaukee County enrollees. At the same time, there is no evidence that ER visits without admission have increased within any specific HMO.

Section 5

Staying Healthy

The principles of managed care as a health care delivery system rely on the concepts of promoting health and avoiding illness. These goals may be viewed as leading to long-term cost savings, as well as being quality of care indicators.

Lead screening of children at an early age may prevent the long-term consequences of untreated lead toxicity. The children in the Aid to Families with Dependent Children (AFDC)/Healthy Start population may be at increased risk because of housing conditions. It is important that lead screening be carried out on a predictable schedule so that early treatment may be carried out when necessary.

Preventing illness through immunization is a principle of public health that is a cornerstone of managed care. The need to provide and document timely immunization to children is a goal shared by the Division of Health Care Financing (DHCF), Medicaid HMOs, and the public health departments. Reporting on immunizations is hampered by incomplete data capture where private and public providers do not have access to a single database. A goal of the Wisconsin Immunization Registry is to alleviate data access and reporting problems.

Managing pregnancy to achieve successful birth outcomes is a vital concern for this population because of the high percentage of women of childbearing age in this population.

Lead Screening

Lead poisoning remains an important threat to the health of children. Lead can adversely affect all systems of the body. A major concern for children exposed to lead is the devastating effect lead can have on the developing brain. The outcome of children exposed to lead depends on the amount of exposure and the age of the child at the time of exposure. Exposure in the first three years of life is associated with the most damage. Very high levels of lead exposure may cause seizures, coma and death while lower levels may result in developmental delays, learning disabilities, behavioral problems, impaired hearing and stunted growth. A verified blood lead level of 20 µg/dl is the level above which treatment or intervention should be considered.

A recent national estimate showed that 21.9% of black children living in large cities, in homes built before 1950 containing lead-based paint, had elevated blood lead levels.[1] According to the 1990 U.S. Census, 37 % of all housing in Wisconsin was built before 1950.[2] It is estimated that in the mid-70s in the U.S. as many as 40% of all American children under age 5 had average blood lead levels of 20 µg/dl.[3] By 1994, 4.4% of all children ages 1-5 years had blood lead levels of 10 µg/dl.[4] This decreased prevalence of lead in children was due primarily to the elimination of lead in paint and gasoline.

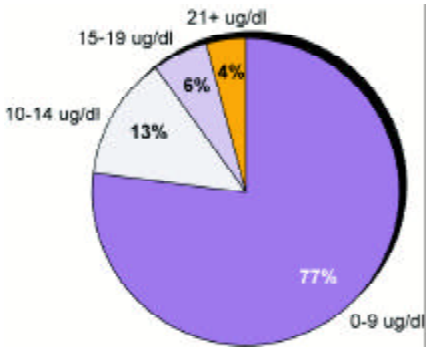
The federal government requires blood lead testing for all Medicaid children at about age 1 and about age 2 years. Wisconsin requires that results of all lead testing done in the state be reported to the Wisconsin Division of Public Health Childhood Lead Poisoning Prevention Program.

In Wisconsin for state fiscal year 1997, 6,187 children less than 6 years of age who were screened had elevated lead blood levels of 10 m/dl or above. Sixty-nine percent of children with elevated levels were found to reside in Milwaukee County. The blood level results for the city of Milwaukee are depicted in Graph 5.1. Of the children tested in Milwaukee, the vast majority are minorities, and of these 68% were black.[5]

The rate of lead screening was twice as high for Milwaukee County HMOs compared to HMOs in the rest of the state. As noted in Graph 5.2, the percent of Milwaukee County Medicaid children tested for lead ranged from 16.4% to 29.9% with an average of 27.4% in 1997. Due to marked delays in claims for lab services and reporting of the results to HMOs, an underreporting of the results has occurred. To facilitate health care providers' ability to monitor, treat and track Medicaid children with elevated lead levels, the DHCF has been working with the Lead Poisoning Prevention Program to join databases. Joining databases will improve the accuracy of data reported as well as allowing the Lead Poisoning Prevention Program an opportunity for working with HMOs to improve case follow-up for children exposed to lead.

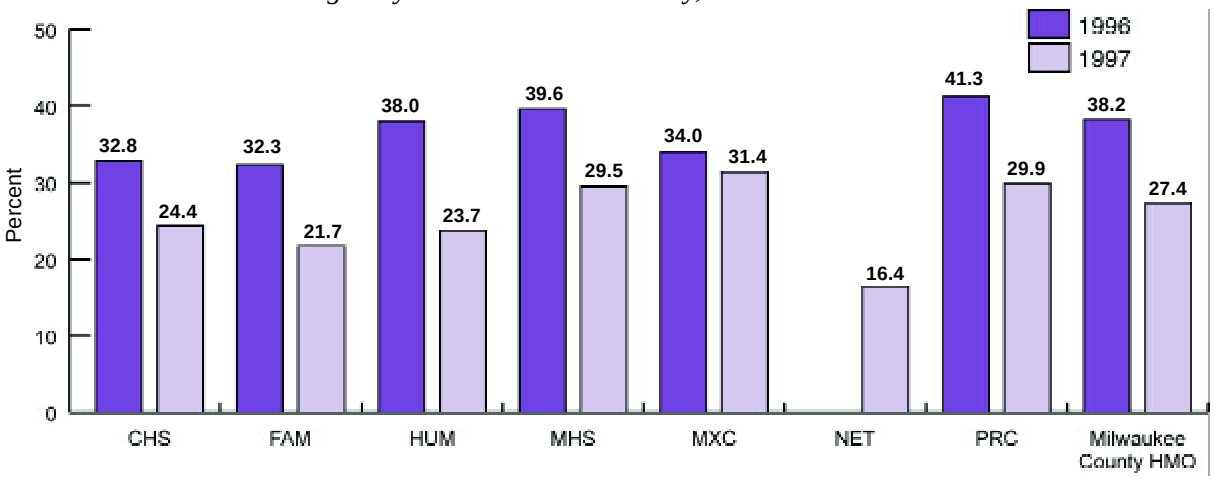
Graph 5.1

Blood lead levels for children tested for lead in Milwaukee, state fiscal year 1996/97



Graph 5.2

Percent of Medicaid children under 6 years of age tested for lead per eligible-year in Milwaukee County, 1996 and 1997



[1] Centers for Disease Control and Prevention. Update: Blood Lead Levels-United States, 1991-1994. MMWR, February 21, 1997; Vol. 46, No. 07: 141-146.

[2] 1990 U.S. Census.

[3] Bellinger, David. "Longitudinal analysis of prenatal and postnatal lead exposure and early cognitive development." New England Journal of Medicine. April 1987. 23:316 (17): 1037-1043.

[4] Centers for Disease Control and Prevention. Update: Blood Lead Levels-United States, 1991-1994. MMWR, February 21, 1997; Vol. 46, No. 07; 141-146.

[5] Wisconsin Childhood Lead Poisoning Prevention Program, January 1998.

Immunizations

Vaccination Preventable Illnesses

Childhood immunizations help keep children enrolled in the Wisconsin Medicaid Program healthy and effectively avoid potential harmful effects of ten vaccine-preventable diseases. Measles, which typically cause a rash and high fever, can also cause pneumonia, deafness or brain damage. Rubella (German Measles) is a mild illness for children, but may cause a pregnant woman who acquires it to lose the baby or cause the baby to have organic abnormalities and developmental disabilities. Many individuals who get polio will be permanently paralyzed. Tetanus attacks the nervous system causing painful muscle spasms and may result in death. Hepatitis B may cause chronic inflammation of the liver and death as a result of liver failure.

Barriers to Immunization

During 1989-91, the United States experienced an outbreak of the vaccine-preventable disease, measles. The primary cause of such an outbreak or resurgence of a vaccine preventable disease has not been the failure of the vaccine to protect, but rather the failure to protect the vulnerable population by delivery of the necessary vaccine at the recommended ages. Barriers existing to achieving full immunization of the vulnerable population include both provider and recipient factors.

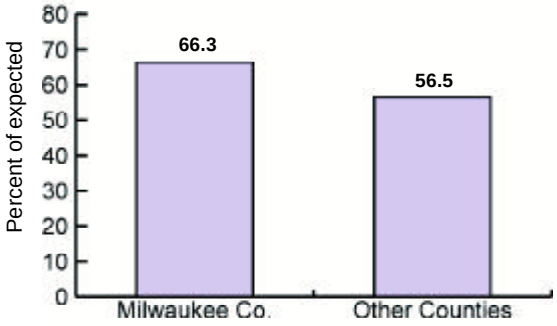
Eligibility to health care through Medicaid is more transient than the commercial population, leading to greater difficulty with establishing a "medical home." The lack of a "medical home," in turn, makes it difficult to provide and monitor immunizations. A centralized, statewide immunization registry is being planned. The registry will assist health care providers with the task of accurately monitoring the immunization history of children in Wisconsin.

Vaccination Monitoring and Goals

Measles, mumps, and rubella (MMR) vaccination is recommended once between 12 and 15 months of age, and again between ages 4 and 6 years. This simple schedule of MMR vaccinations makes it a reasonable measure of immunizations in general.

Graph 5.3

Number of MMR vaccinations as percent of expected, ages 8-24 months, 1997



The Department of Health and Family Services' (DHFS) Strategic Business Plan Year 2001 goal is "to increase to 90% the proportion of children who have received their primary vaccinations by their second birthday."

Percent of Expected Measles, Mumps, and Rubella Vaccinations

The 1996 and 1997 MMR vaccination rates for HMO enrollees were reported for children, ages 8 – 24 months.

The Milwaukee County HMO average MMR vaccination rate, reported as a percent of expected, was 66.3%. For all other counties, the rate was 56.5% (Graph 5.3).

Graph 5.4 shows the MMR immunization rate as a percent of expected immunizations for the Milwaukee County HMO enrollees. Five out of six HMOs participating in Medicaid in 1996 and 1997 reported lower rates of MMR vaccinations in 1997. HMOs with lower rates in 1996 tend to have the lower rates in 1997 as well.

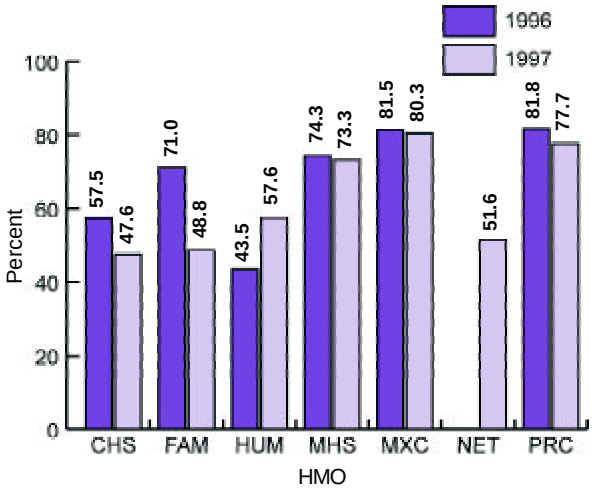
In 1996, the Milwaukee County HMO enrollees received MMR vaccinations at an average rate of 68.1%

of expected. In 1997 the average for Milwaukee County HMO enrollees was 66.3%. The Milwaukee County HMO MMR immunization rate remains stable.

The rate of delivery of MMR vaccinations to non-Milwaukee County HMO enrollees varied from approximately 27% to a high of approximately 84%. The average for the non-Milwaukee County enrollees was approximately 56%, compared to approximately 66% for Milwaukee County enrollees (Graph 5.5).

Graph 5.4

Number of MMR vaccinations as a percent of expected, Milwaukee County, ages 8-24 months, 1996 and 1997[1]



The rate of MMR vaccination does not include the services delivered by public agencies that were not reported or billed to the enrollee's HMO. Since the rate of HealthCheck services delivered to this age group is nearly 95%, and HealthCheck services include a review of immunization status, it is likely that there is considerable under-reporting of immunizations. The data validity audits performed by the DHCF for each of the participating HMOs suggests that there is under-reporting of results from service delivery outside of the HMOs as well as improper coding of services within the HMOs. Within the last year, several HMOs have chosen immunizations as the topic for a focus study and are exploring ways to improve both delivery and recording of immunization services. The DHCF, in cooperation with participating HMOs, may be able to identify a "best practice" which can be shared with all Medicaid providers.

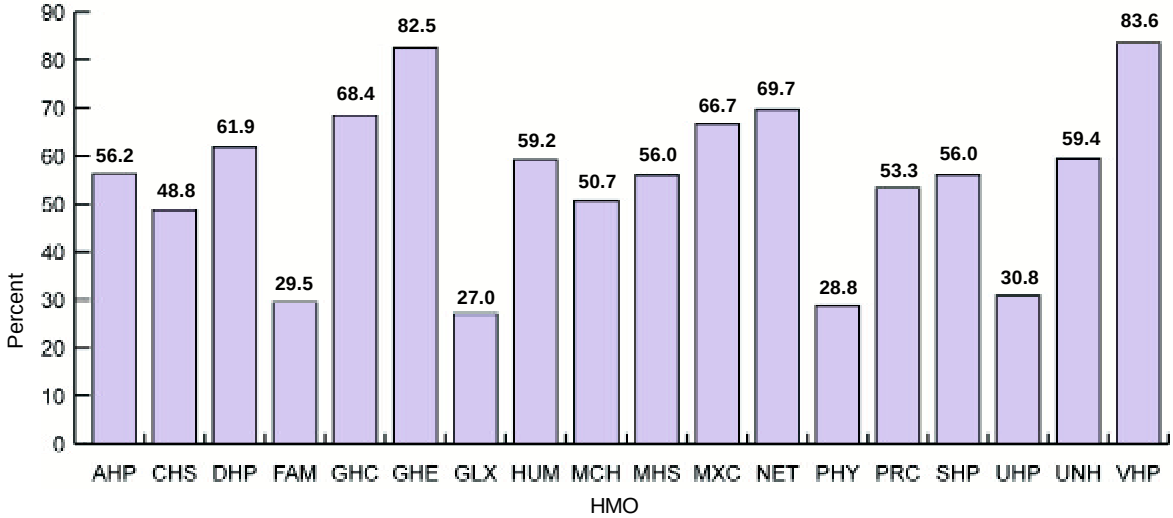
Summary

The data showed that preventive health services for children (lead screening and MMR vaccination) are below standards with little change over 1996. Some caution must be exercised when reaching this conclusion because other agencies may provide lead screening and immunizations.

[1] Network Health Plan did not contract for the entire year in 1996 and is not included.

Graph 5.5

Number of MMR vaccinations as percent of expected, other counties, ages 8-24 months, 1997



Pregnancy and Birth Outcomes

The Medicaid Program strives to ensure that all pregnant enrollees have access to services that will aid in a healthy birth outcome. Prenatal Care Coordination (PNCC) programs have been used by the HMOs to assess women at risk and provide health exams, health education, nutrition counseling and other health promotion activities. In 1997, seven of the HMOs chose to study prenatal care in more depth by selecting it as a topic for their focus studies.

In the U.S., one-third of all births between 1991-1995 were to women enrolled in Medicaid for at least part of their pregnancy.[1] The number of deliveries to Wisconsin Medicaid recipients served by HMOs nearly doubled with 5,922 deliveries in 1996 and 11,319 deliveries in 1997. The greatest increase occurred in non-Milwaukee counties due to HMO expansion (Graph 5.6).

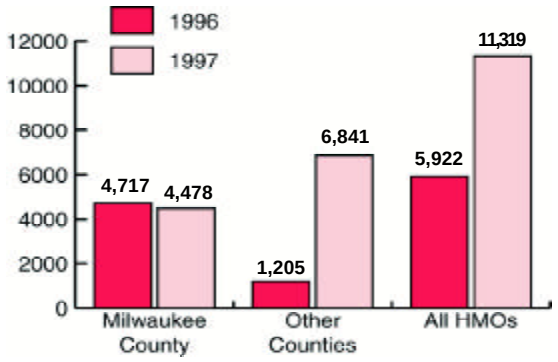
Maternal factors that have been found to be associated with infant mortality include beginning prenatal care after the first trimester of pregnancy, being a teenager or 40 years of age or older, not completing high school, being unmarried, and smoking during pregnancy.[2] Many of the Medicaid pregnant women exhibit one or more of the maternal factors associated with infant mortality.

Each year in the U.S., almost 500,000 teenagers give birth. The birth rate for Wisconsin teens aged 15-19 years was 37.6 births per 1,000 females compared to the national rate of 54.7 births.[3] Teenage mothers are more likely than older mothers to not receive timely prenatal care, to smoke, and to have a low birth-weight infant.[4]

In 1997, of the 11,319 deliveries to enrollees, 3,767 births were to females 12-20 years old. Expressed as a percentage of all deliveries, the number of deliveries to women ages 12-20 declined to 33.3% in 1997 from 36.8% in 1996 (Graph 5.7).

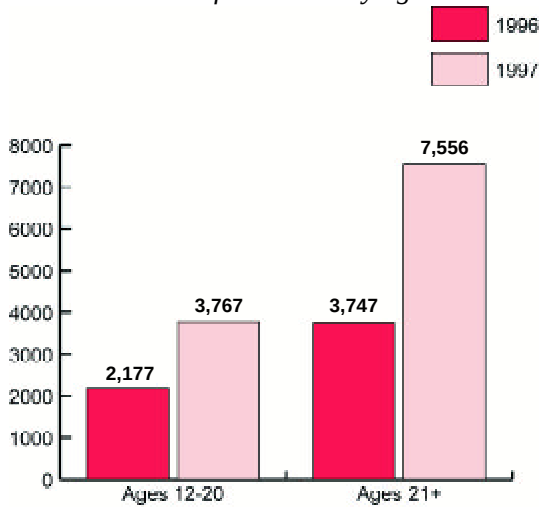
Graph 5.6

Number of deliveries



Graph 5.7

Number of deliveries by age



[1] Amba, J.C., et al. Fertility, family planning and women's health. National Center for Health Statistics, 1997.

[2] Center for Disease Control and Prevention/National Center for Health Statistics. Monthly Vital Statistics Report, Vol. 46, No. 12, Supp. Aug. 27, 1998.

[3] Center for Health Statistics, Department of Health and Family Services. Wisconsin Births and Infant Deaths, 1996.

[4] National Vital Statistics System. Teenage Births in the United States: National and State Trends, 1990-96 (PHS) 98-1120 (4/30/98).

C-Section and Vaginal Births

Compared to vaginal deliveries, cesarean sections (C-sections) have been associated with greater mortality, morbidity, and longer lengths of hospital stays. From 1970 to 1995, the rate of cesarean delivery in the United States rose from 5 to 21%.[1] The goal of the national Healthy People 2000 initiative is to reduce the cesarean rate to no more than 15 per 100 deliveries. While the national cesarean rate was 21% in 1995, Wisconsin's rate of 15.7 per 100 deliveries ranked as one of the lowest in the nation.[2]

C-Sections

In 1997, the overall percentage of cesarean deliveries to Medicaid recipients (12.0%) met the Healthy People 2000 goal. This was a slight decrease from the 13.5% in 1996. The rate of deliveries that were cesarean in 1997 was 9.5% for recipients in Milwaukee County and 13.6% for recipients in the rest of the state (Graph 5.8). Graph 5.9 presents the percentage of deliveries that are C-Sections by age.

The low rates of cesarean deliveries has to be interpreted with caution since the rates have not been adjusted for risk factors and cannot be linked to complication rates and birth outcomes. In conclusion, low rates of cesarean deliveries are only desirable when safe vaginal deliveries can be assured.

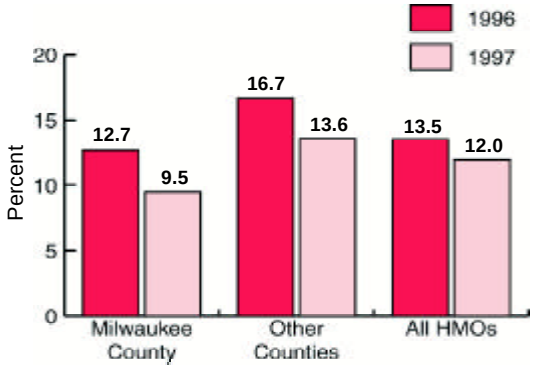
Vaginal Births After C-Section

In recent years, vaginal births after a C-section (VBACS) delivery have been considered a safe option for many women. As the number of VBACS increase, so will the number of reported complications. The risks of VBACS must be weighed against the risk of complications from cesarean delivery.

Experts are now contending that strategies proposed to reduce cesarean deliveries by increasing the number of vaginal deliveries among women who have had cesarean deliveries and increasing the number of operative vaginal deliveries, are associated with uterine ruptures and neonatal trauma.[3]

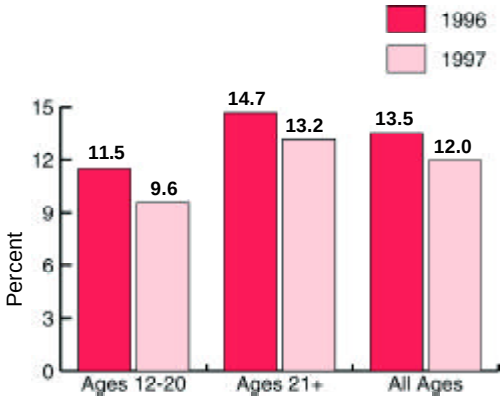
Graph 5.8

Percentage of deliveries that are C-sections, 1996 and 1997



Graph 5.9

Percentage of deliveries that are C-sections, by age, 1996 and 1997



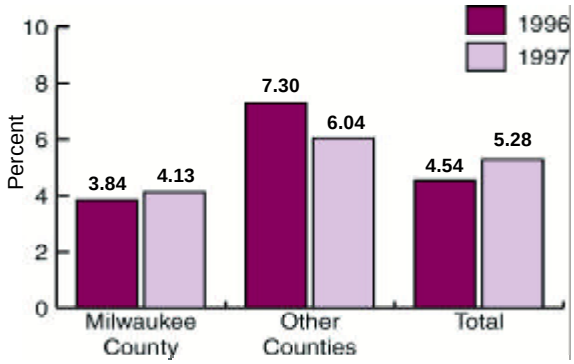
The overall rate of VBACS performed for HMO enrollees showed a slight increase with 5.3% in 1997 compared to 4.5% in 1996. Rates of VBACS were higher for non-Milwaukee county HMOs (6.0%) than Milwaukee County HMOs (4.1%) (Graph 5.10). Drawing conclusions from the data is difficult without information about outcomes among women undergoing VBACS and complication rates in both the mother and the neonate.

Summary

The C-section rate continues to meet federal goals. There were fewer C-sections in Milwaukee County than in the rest of the state. This could be because Milwaukee County is urban and delivery services are in closer proximity than in many rural counties of Wisconsin.

Graph 5.10

Percentage of deliveries that are VBACS



[1] U.S. Public Health Service, U.S. Department of Health and Human Services. Monthly Vital Statistics Report, Center for Disease Control and Prevention. July 1997.

[2] Health Care State Ranking, 1997.

[3] Sacghs, B., Castrol, M., & Frigoletto, F. "The risks of lowering the cesarean delivery rate." The New England Journal of Medicine. Jan. 7, 1999; Vol. 340, No. 1.

Section 6

Getting Better

The ability of HMO enrollees to access care for established diagnoses is essential to achieving wellness. Once a diagnosis is established, a plan of care is usually required to regain normal health.

Services may be provided by subcontracted providers so that complete data are not always available to the HMO for tracking and reporting purposes. In addition, issues of data confidentiality arise when data sharing is requested. Evaluation of the process(es) necessary to achieve good outcomes of treatment is thus impeded.

Mental health and substance abuse (alcohol and other drug abuse) treatment services are important components of care for Wisconsin Medicaid recipients. The Division of Health Care Financing (DHCF) is continuing to work with providers in an attempt to respond to the challenges that surround the delivery of these services.

Mental Health Services

According to a recent national Healthy People 2000 Progress Review, the one-year prevalence of mental illness in the U.S. was 16% in 1992 among non-institutionalized non-rural whites, blacks and Hispanics, aged 18-54. Among that same population, the one-year estimated prevalence of depressive disorders was 11.1% overall and 13.1% in females.[1]

The National Institute of Mental Health estimates that the most severe mental illnesses affect some 5 million American adults. In 1996, Wisconsin estimates of prevalence of serious mental illness ranged from 5.5% in Kenosha and Waukesha Counties to 6.9% in Dane County among the 5 counties represented in this report.[2] Most Medicaid recipients with disabling mental illness are cared for elsewhere in the Medicaid program and not in HMOs.

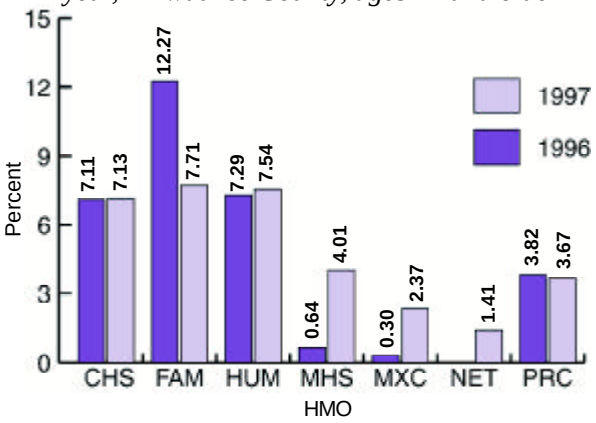
Mental illness can occur from childhood to old age, irrespective of gender and race. Overall, one in ten Americans experience some disability from a diagnosable mental illness in the course of any given year.[3] Most psychiatric disorders are very responsive to appropriate treatment, however, not everyone with mental illness receives care.

The reasons for failure to receive care include denial or lack of awareness that a problem exists, a feeling that a stigma is associated with seeking care, refusal of or lack of compliance with suggested treatment, and problems with access to care.

The American Managed Behavioral Healthcare Association (AMBHA) is working to develop uniform reporting of mental health and substance abuse services, recognizing that "National norms indeed are difficult to come by and the problem has only intensified with the proliferation of behavioral health performance measures produced by industry, government, and consumer groups."[4]

Graph 6.1

Percent of eligibles receiving mental health day treatment and/or outpatient services per eligible year, Milwaukee County, ages 21 and older



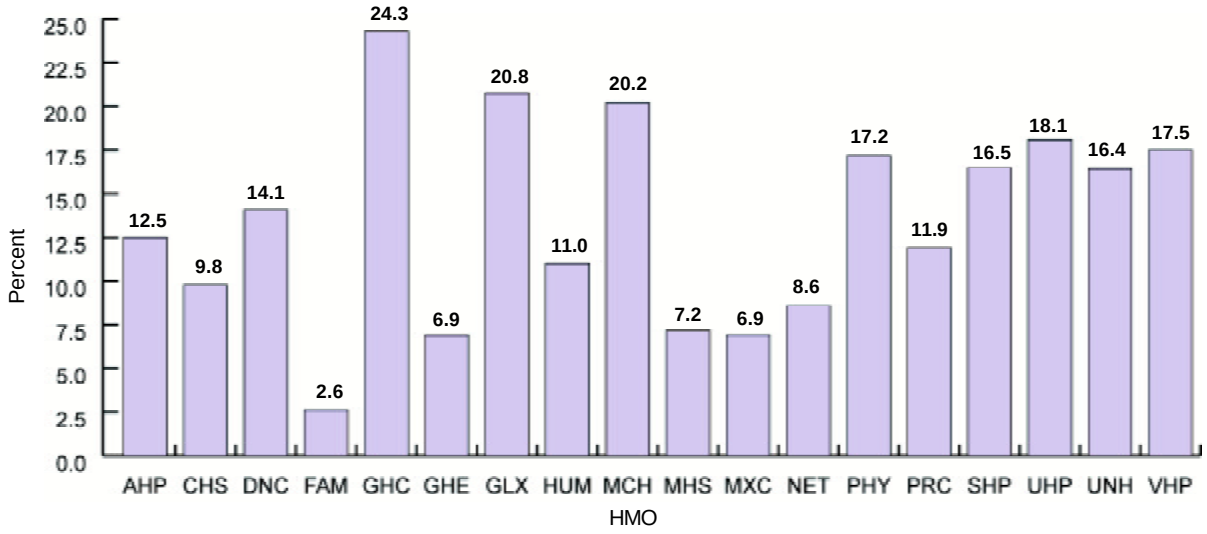
This report presents findings related to services provided in 1997 by *mental health professionals* to Medicaid Aid to Families with Dependent Children (AFDC)/ Healthy Start HMO recipients. It does not include utilization data relative to services provided by providers who are not specialized in mental illness care such as primary care physicians.

The reported services in this section must be interpreted with caution. The data reported may depend on information supplied by a subcontracting provider who may not be always diligent about providing complete data at this time even though contractually obligated to do so. Future data validity audits will be conducted to assess and address this situation as warranted. The HMO-reported data may not include the actual number of services, but just number of enrollees who received the service.

It is also unwarranted to compare this population as a whole with national prevalence rates. The HMO population is predominantly young—60% are age 10 or younger. Significant mental illness is less often diagnosed in young children.

Graph 6.2

Percent of eligibles receiving mental health day treatment and/or outpatient services per eligible-year, other counties, ages 21 and older, 1997



Outpatient Mental Health Care

These graphs do not include data on evaluations or assessments for mental illness or substance abuse. Historically, outpatient mental health care consisted almost entirely of psychotherapy and medication provided in an outpatient office or clinic on a fairly limited basis (one hour per week or less). Such care is appropriate for a wide range of diagnoses and severity levels, including some with long-term mental illnesses who do not have access to other forms of treatment such as Community Support Programs (CSP). Day treatment services were developed in response to a need for a level of care more intense than traditional outpatient psychotherapy, yet less disruptive than inpatient treatment. Day treatment provides for more treatment hours per week in a structured setting and is appropriate for individuals with more serious or severe mental illness. Mental health day treatment patients are typically persons with long-term mental illness in maintenance, rehabilitation, or stabilization categories. It is also used after an inpatient discharge as a transition to outpatient care and often referred to as "transitional care." Day treatment programs for children and adults are not available in every city or county, so this report presents aggregate day treatment and non-day treatment outpatient care.

Graph 6.1 shows comparable data for mental health day treatment and/or outpatient services for Milwaukee County enrollees for 1996 and 1997. The average for this group is 5.1% eligibles receiving per eligible-year.

Graph 6.2 shows a wide variation in the rate of HMO enrollees outside Milwaukee County receiving mental health services. While this may reflect a true variance in rate of service delivery, a portion of the variance may be due to incomplete capturing and reporting of data. HMOs are contractually required to have all third-party vendors submit all required data. The overall average for the rest of the state is 13.2%, more than twice the rate of 5.1% within Milwaukee County.

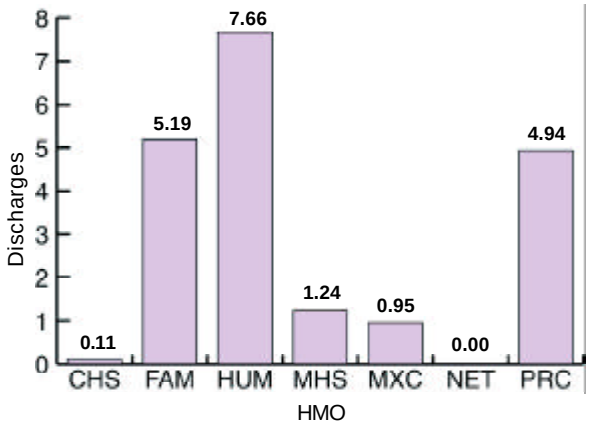
Inpatient Mental Health Care

The wide variation in reported discharges per 1,000 eligible-years suggests that data capture and reporting may be a problem in this area of health care delivery. It is unlikely that HMOs serving a single area would have variations in mental health discharges ranging from 0.00 to 7.66 discharges per 1,000 eligible-years. Using the reported data, the average for the Milwaukee County enrollees is 3.69 discharges per 1,000 eligible-years (Graph 6.3).

The wide variation in reported psychiatric discharges is even more pronounced in the HMO data for the rest of the state. While some of the variation in this group may well reflect differences in this population's use of services, it is likely that problems related to data capturing and reporting are also reflected in this data. Further, wide variation may also result from the relatively small size of some of the HMOs combined with hospitalizations being a relatively rare event. There is a range of activity from 0 to approximately 12.9 discharges per 1,000 eligible-years. The average for this group of HMOs is 3.5 discharges per 1,000 eligible-years, not dissimilar to the average discharge rate in Milwaukee County (Graph 6.4).

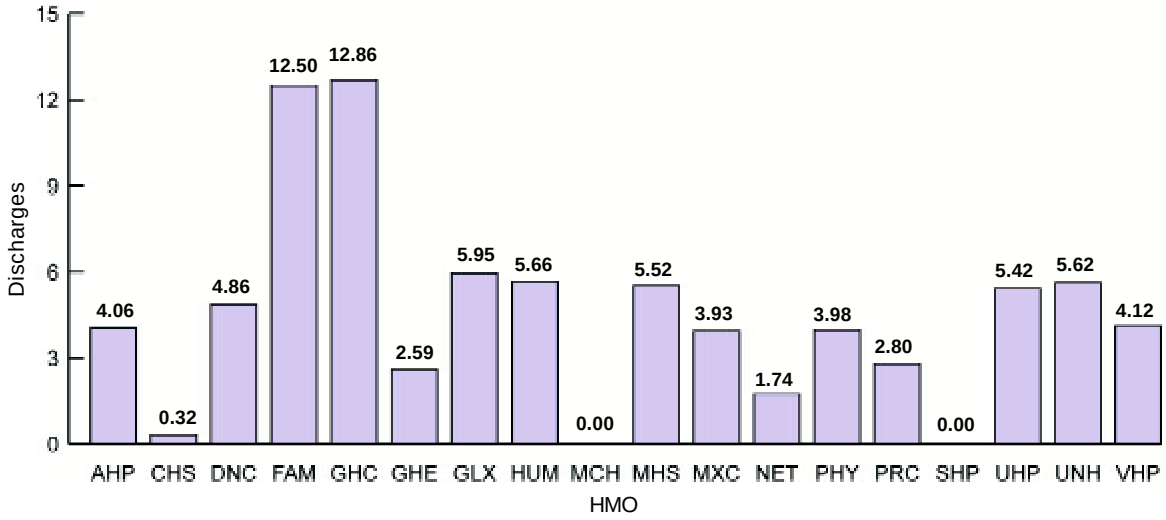
Graph 6.3

Psychiatric discharges per 1,000 eligible-years, Milwaukee County, 1997



Graph 6.4

Psychiatric discharges per 1,000 eligible-years, other counties, 1997



Substance Abuse Services

Substance abuse, the inappropriate use of drugs and alcohol, is a problem in Wisconsin and the U.S. because of health and social problems associated with such behavior. The 1997 National Household Survey on Drug Abuse estimated that 13.9 million Americans were current users of illicit drugs. The illicit drug usage among the overall population remained steady, but the usage among 12- to 17-year-olds increased from 9.0% in 1996 to 11.4% in 1997.[5] In 1993, the Wisconsin Department of Public Instruction conducted the Wisconsin Youth Risk Behavior Survey designed to determine levels of risk-taking behaviors among high school students. In that survey, 3% of all 9th through 12th graders (approximately 14-18 years old) admitted trying cocaine, and 17% admitted trying marijuana. Alcohol use was more prevalent than cocaine and marijuana use and tended to increase with age. Twenty percent of 9th graders compared to 39% of 12th graders admitted drinking "five or more drinks in a row."[6]

Data released from the national Substance Abuse and Mental Health Service Administration (SAMHSA) indicated that individuals admitted for substance abuse treatment were less likely than the general population to have completed high school or to be employed full time. Thirty-four percent of those admitted for treatment did not complete high school compared to 19% of the general population.[7]

Substance Abuse Treatment

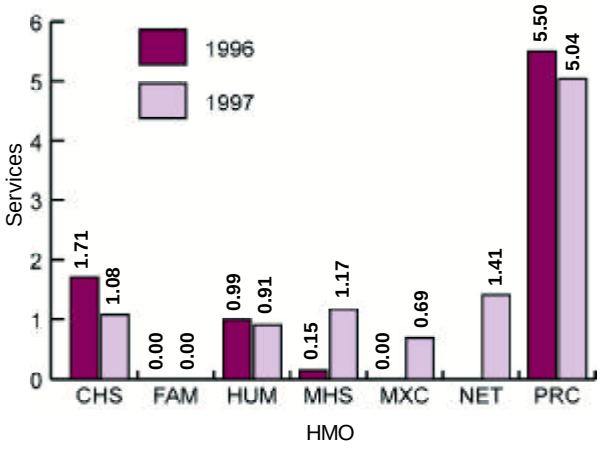
The average percent of enrollees in Milwaukee County receiving substance abuse day treatment or outpatient services is 2.4% of all eligibles receiving treatment per eligible-year (Graph 6.5). These graphs do not contain data on evaluation or assessments for substance abuse services.

The wide range of the percent of eligibles receiving substance abuse day treatment or outpatient services per eligible-year between HMOs serving a single, well-defined population may reflect differences in service delivery, but they may also reflect problems with capturing and reporting data. It is likely that some substance abuse services in the day treatment or outpatient setting are provided by public agencies that do not report the services to the enrollee's HMO. The regional Medicaid Managed Care Mental Health and Substance Abuse workgroups are developing collaborative efforts between HMOs and other public and private agencies to improve collection and sharing of data in this area.

For substance abuse day treatment and/or outpatient services for the enrollees in other counties, the average is 3.17% of eligibles ages 21 and older receiving treatment per eligible-year. Again, it is likely that the wide range reported, from 0% to 15.4%, between HMOs reflects both service delivery and differences in data capturing and reporting. Enrollees receiving services from community or public agencies, where services probably would not be reported to the HMO, are not included in the data (Graph 6.6).

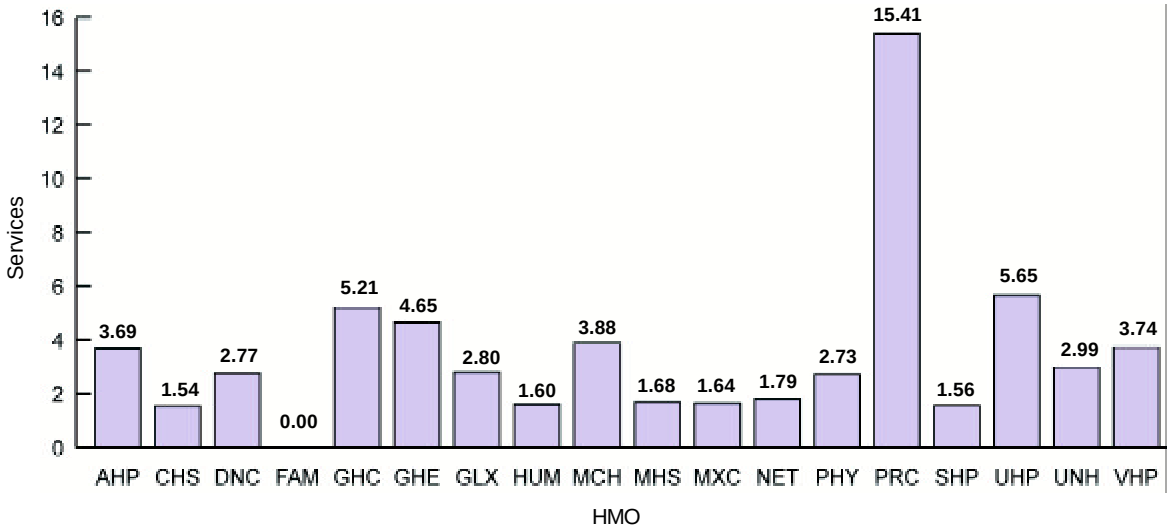
Graph 6.5[8]

Percent of eligibles receiving substance abuse day treatment and/or outpatient services per eligible year, Milwaukee County, ages 21 and older



Graph 6.6

Percent of eligibles receiving substance abuse day treatment and/or outpatient services per eligible year, ages 21 and older, other counties, 1997



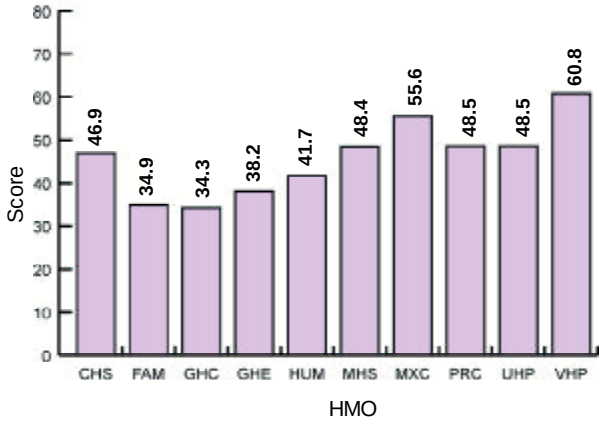
Quality of Care Audit

For those recipients who did receive outpatient mental health or substance abuse care, the DHCF conducted a chart audit as one indicator of the quality of care provided. This audit took a random sample of those recipients who had five or fewer reported services in 1995. Enrollees in nine HMOs in Milwaukee, Dane and Eau Claire counties were included in the audit.

Graph 6.7 shows the scores achieved by the HMOs. Six HMOs obtained scores that were significantly better than the average of 44.6 while four obtained significantly lower scores.

Graph 6.7

Mental Health/Substance Abuse chart audit scores



Access Audit

An access audit focused on the absence of a reported mental health/substance abuse (MH/SA) service in the presence of a MH/SA diagnosis between July 1, 1996 and June 30, 1997. Ten HMOs in the Wisconsin Medicaid program in 1996-97 were included in the audit. Of those recipients with MH/SA diagnosis and no reported MH/SA services:

- Less than 5% of enrollees had a MH/SA diagnosis and actually received no service for it.
- About 20% of the MH/SA diagnoses reported were found to not be true MH/SA diagnoses.
- About 15% of the enrollees for whom no MH/SA service was reported had actually received MH/SA services.
- Almost 50% of enrollees with a MH/SA diagnosis received a service for it from a non-MH/SA professional, usually a primary care physician. The most common diagnoses in this group were Attention Deficit Disorder and Attention Deficit Hyperactivity Disorder, which were often treated by pediatricians.
- About 10% of the enrollees received a service for the MH/SA diagnosis either before or after the audit period.

Summary

Recipients with mental illness are among the most vulnerable and least likely to self-advocate. For this reason, monitoring the provision of behavioral health services will remain a Department of Health and Family Services (DHFS) priority. Data collected to date indicate a general need to improve data collection procedures. Data collection is difficult because there is a relative lack of standardization within behavioral health regarding issues such as service units and types of service. In addition, many HMOs provide behavioral services through subcontracted specialty firms which makes them, and the DHFS, one step further removed from the data. The DHFS will continue to work with the HMOs to improve data collection. Collecting encounter data beginning in the year 2000 will help to alleviate this problem. The available data does suggest differences between the behavioral health care provided by HMOs in Milwaukee County versus HMOs in the rest of the state. These differences will be explored in a Recipient Behavioral Health Satisfaction Survey scheduled for early 1999.

[1] Healthy People 2000 Progress Review: Mental Health and Mental Disorders, July 9, 1996.

[2] Bureau of Community Mental Health.

[3] National Institute of Mental Health. 1996-98 Mental Illness in America, the National Institute of Mental Health Agenda.

[4] Medical Outcomes and Guidelines Alert. Vol. 6 No. 18, Sept. 14, 1998.

[5] Substance Abuse and Mental Health Services Administration. Preliminary Results From the 1997 National Household Survey on Drug Abuse. August 1998. Contact: Office of Communications.

[6] 1993 Wisconsin youth risk behavior survey. Wisconsin Department of Public Instruction.

[7] Substance Abuse and Mental Health Services Administration. Preliminary Results From the 1997 National Household Survey on Drug Abuse. August 1998. Contact: Office of Communications.

[8] Network Health Plan did not contract for the entire year in 1996 and is not included.

Section 7

Living with Illness

Certain states of illness do not have an established cure. For such conditions treatment is necessary to maximize quality of life.

Asthma is amenable to treatment such that the quality of life is markedly improved when treatment is successful. A measure of the quality of care delivered by managed care is the ability of patients with asthma to avoid the use of emergency room services, and especially inpatient admission resulting from an emergency room visit.

Diabetes mellitus has complications that can be ameliorated with appropriate therapy. Monitoring blood glucose frequently enough to maintain a nearly normal blood glucose level has been demonstrated to provide improved long-term outcomes. The availability of monitoring tests for patients with diabetes, and careful follow-up by providers with appropriate adjustments in treatment, can prevent or markedly delay the onset of debilitating complications of uncontrolled diabetes.

Asthma

Asthma is one of the nation's most common and costly diseases, and affects more than 15 million Americans, including almost 5 million children.[1] The total health care costs related to asthma were estimated to $6.2 billion in 1990, and are projected to double to $14.5 billion by the year 2000.[2]

Asthma is a chronic lung disease characterized by temporary obstruction of airflow resulting in difficult breathing. Asthma affects all ages, both sexes, and all racial groups. Risk factors for developing asthma include living in the inner city, having a parent with asthma, living with a smoker, being born premature, and having allergies.

The prevalence is much higher among blacks than whites.

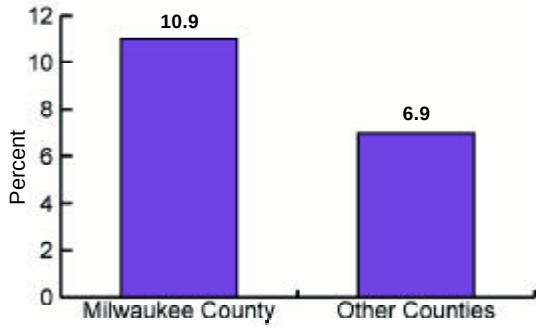
Asthma is the most prevalent chronic disease and the most frequently reported potentially preventable condition for which children are hospitalized.[3] In 1995, the asthma-related rate of emergency room visits was 48.8 per 10,000 among whites and 228.9 per 10,000 among blacks.[4] Between 1979 and 1994, hospitalization rates for asthma were 10.9 per 10,000 visits among whites and 35.5 per 10,000 visits among blacks.[5]

Hospitalizations for Asthma

In 1997, 3,206 non-Milwaukee County HMO members ages 0-20 had a primary diagnosis of asthma, and 220 of those enrollees were admitted to a hospital with that primary diagnosis. This represents an admission rate of approximately 7% . In the Milwaukee County HMOs 4,232 enrollees, ages 0-20, had a primary diagnosis of asthma and 461 of that number were hospitalized with that primary diagnosis. Thus, approximately 11% of Milwaukee County HMO enrollees with a diagnosis of asthma were hospitalized with that primary diagnosis in 1997 (Graph 7.1).

Graph 7.1

Percent of enrollees with a primary diagnosis of asthma, admitted to an inpatient hospital, ages 0-20 years, 1997



The 1996 average for asthma admissions for Milwaukee County HMO enrollees ages 0-20 years was 12.5%. The 1997 average admission rate of 11% for Milwaukee County enrollees with a diagnosis of asthma represents improvement. The Milwaukee County decrease in admissions for an asthma diagnosis may reflect the inter-HMO cooperative efforts in managing this disease through a disease management strategy adopted by several Milwaukee County HMOs.

The data for enrollees age 21 and over show that 1,148 enrollees in non-Milwaukee County HMOs had a diagnosis of asthma, and 41 of that number, or almost 3.5% of the total, were hospitalized for a diagnosis of asthma. Of the 1,660 Milwaukee County HMO enrollees (21 years of age and over) diagnosed with asthma, 87, or approximately 5%, were admitted to the hospital for asthma (Graph 7.2). In 1996 the average Milwaukee County admission rate for this age group was 8.6%. The lower rate of admissions in Milwaukee County for this age group, again, is probably a reflection of inter-HMO cooperative efforts to develop effective disease management strategies for enrollees with asthma.

Summary

Hospitalizations resulting from asthma have declined for children and adult enrollees in Milwaukee County HMOs since 1996. There is insufficient data available for 1996-97 comparison data for the non-Milwaukee County HMO enrollees. The development and implementation of care management for enrollees with asthma, resulting from inter-HMO cooperative efforts, will likely result in further reduction of hospitalizations for this population of Wisconsin Medicaid enrollees.

[1] Centers for Disease Control and Prevention – National Center for Environmental Health, October 1997.

[2] Centers for Disease Control and Prevention – National Center for Environmental Health, October 1997.

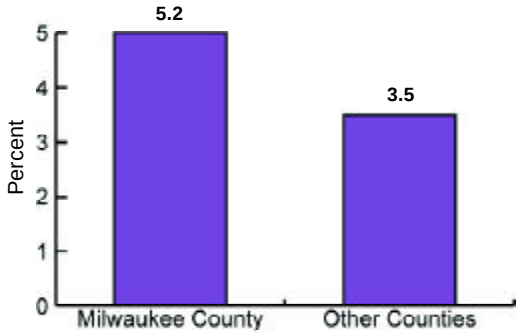
[3] Wisconsin Department of Health and Family Services – Children's Health in Wisconsin. State Estimates. November 1996, 28-29.

[4] Centers for Disease Control and Prevention – Asthma Rates in U.S. Increase. Media Release, April 24, 1998.

[5] Centers for Disease Control and Prevention – Asthma Rates in U.S. Increase. Media Release, April 24, 1998.

Graph 7.2

Percent of enrollees with a primary diagnosis of asthma, admitted to an inpatient hospital, ages 21 and older, 1997



Diabetes Mellitus

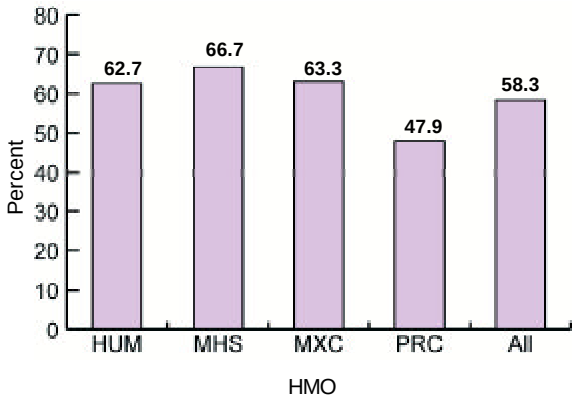
Diabetes is the seventh leading cause of death in the United States, contributing to more than 193,000 deaths in 1996.[1] Diabetes is a group of diseases characterized by elevated blood glucose levels resulting from defects in insulin secretion, insulin action, or both. People with diabetes are at increased risk of serious health complications including blindness, kidney failure, nerve damage, cardiovascular disease, stroke and amputation of lower extremities. This disease strikes individuals of all ages, socioeconomic groups, and ethnic groups.

Studies have shown that many of the complications of diabetes can be slowed or even prevented with good control of blood sugar. The Diabetes Control and Complication Trial, a national 10-year study that involved individuals with Type 1 diabetes, confirmed that good control of blood sugar prevented the onset or delay of progression of kidney, eye, or nerve damage by 50%.[2]

Glycohemoglobin is a lab test used to quantify glucose control over the previous three months. The test has proven to be valuable in validating the degree of glycermic control. For 1997, the Division of Health Care Financing (DHCF) had selected as an objective that 100% of all Medicaid enrollees with a diagnosis of diabetes that are continually enrolled for 12 months will have had one glycohemoglobin test. HMOs with fewer than 30 Medicaid enrollees diagnosed with diabetes and meeting the 12 month continuous enrollment criteria are not reported. The average percentage of Medicaid enrollees with diabetes reported to have at least one glycohemoglobin level during 1997 was 58.3% (Graph 7.3). The rates varied for the HMOs. This variance may be due to the data collection methodology chosen by the HMO and coding and reporting experience the HMOs have with this indicator. HMOs that chose to only rely on administrative claims data rather than chart review data may report lower rates.

Graph 7.3

Percentage of Medicaid recipients with diabetes who had at least one glycohemoglobin level in 1997



Guidelines have been developed to assist Wisconsin health care providers in caring for patients with diabetes mellitus improve case outcomes.[3] In the future, the DHCF will assess the quality of medical care provided to Medicaid enrollees with diabetes mellitus by monitoring the number of eye exams provided to recipients with the diagnosis of diabetes. Retinopathy is a known common complication of diabetes. Therefore, an annual comprehensive dilated eye and visual exam is one valid indicator for monitoring the medical management of individuals with diabetes.

[1] Centers for Disease Control and Prevention. Diabetes – A serious public health problem, At-A-Glance, 1999.

[2] Centers for Disease Control and Prevention. Diabetes – A serious public health problem, At-A-Glance, 1999.

[3] The Wisconsin Diabetes Advisory Group. Essential Diabetes Mellitus Care Guidelines, Jan. 1998.